

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15119

1. PLACE OF DEATH

County Jackson
Towship Law
City Kansas City (No. 6821)

Registration District No. 399
Primary Registration District No. 1002
Chestnut

File No. _____
Registered No. 1002
St. _____ Ward _____

2. FULL NAME Baby Boy M. Anally

(a) Residence. No. 6821 Chestnut St., _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 14 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 7 hrs. or — min.
Months

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Luther M. Anally

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Belton
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Esther Hand

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) London, Ohio
(STATE OR COUNTRY)

14. INFORMANT Luther M. M. Anally
(Address) 6821 Chestnut

15. May 15 1927 M. M. Crowe
FILED REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1927

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1927 to May 14, 1927 that I last saw h. — alive on May 13, 1927, and that death occurred, on the date stated above, at 5:24 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity 6 mos.
160B 161A
159 (duration) yrs. mos. da.
CONTRIBUTORY Placenta previa
(SECONDARY) hemorrhage
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Geo. C. Mosher, M. D.

715, 1927 (Address) 605 Bryant Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mt. Moriah 5-16 1927

20. UNDERTAKER ADDRESS

Eyles Bros 1800 Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

