

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

Do not use this space.

30428

1. PLACE OF DEATH

County Jackson Registration District No. 1002
 Township Kan Primary Registration District No. 1002
 City Kansas City (No. K.C. General Hosp)

File No. 3935
 Registered No. 3935
 St. _____ Ward _____

2. FULL NAME

Nicholson Donald
 (a) Residence. No. 5637 Ramona 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 11 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
6

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) _____ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Leonard Nicholson

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

12. MAIDEN NAME OF MOTHER Edith Thornton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) England

14. INFORMANT Donald Clerk (Address) K.C. General Hosp.

15. FILED 10-18-27 M. M. Crowe REGISTRAR
asch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-16 1927

17. I HEREBY CERTIFY That I attended deceased from 10-16, 1927 to 10-16, 1927 that I last saw him alive on 10-16, 1927 and that death occurred, on the date stated above, at 6:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital debility
157 1614 (duration) _____ yrs. _____ mos. _____ da.
157

CONTRIBUTORY Prematurity (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

no IF NOT AT PLACE OF DEATH. _____
 DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Post Mortem Findings
 (Signed) P. Williams M. D.

10-17-27 (Address) Subt K.C. Gene Hosp.

*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 St. Washington DATE OF BURIAL Oct 18 1927

20. URDERTAKER Mrs G. L. Foster ADDRESS K6 mo

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.

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