

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Kansas City (No. 1276 Independence) St. _____ Ward _____

File No. 4853
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Raymond H. Stephenson
 (a) Residence. No. 1276 Independence 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. **4. COLOR OR RACE** Colored **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single

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

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

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
1 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (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) Missouri

10. NAME OF FATHER Raymond H. Stephenson

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

12. MAIDEN NAME OF MOTHER Roselle Cuttys

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

14. INFORMANT (Address) Roselle Stephenson 1216 Independence

15. FILED 2-4-28 M. M. Crowe REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1-28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accident - Suffocation
1928
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (Red clothes)
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 180
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
 (Signed) W. Weaver, M. D.
 (Address) Deputy Coroner

*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 Blue Ridge Lawn **DATE OF BURIAL** 2/4 1928

20. UNDERTAKER Hatkins Bros. **ADDRESS** 1729 Luma

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.

MISSOURI STATE BOARD OF HEALTH

