

**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. 399 File No. 5034
 Township Ran Previous Registration District No. 1005 Registered No. 657
 City R.P. Mo. (No. Old City Hospital) St. Mo. Ward

2. FULL NAME

Infant Irwin J
 (a) Residence No. 1228 Michigan St. Mo. Word. Mo.
 (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 Male 4. COLOR OR RACE Colored 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) Feb 11, 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 2 hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
 (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) R.P. Mo.

10. NAME OF FATHER Moses Irwin

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

12. MAIDEN NAME OF MOTHER Mattie Webb

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

14. INFORMANT Old City Hospital
 (Address) 22 Cherry St

15. FILED 7/16/28 M. M. Crowe
 19 28 REGISTRAR Acas

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-11 19 28

17. I HEREBY CERTIFY, That I attended deceased from 2-11-28 to 19 that I last saw him alive on 2-11, 19 28, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
159 (duration) yrs. mos. ds.
16/16 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) H. M. Smith, M. D.
2-11, 19 28 (Address) Old City Hospital

*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 Seeds Cemetery DATE OF BURIAL 1820E 19

20. UNDERTAKER AB Moore ADDRESS 1820E 18

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

