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

Do not use this space.

13519

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: Kaw — Primary Registration District No.: 1002 — Registered No.: 1859
City: Kansas City (No. Kansas City Genl Hosp St. Ward)

2. FULL NAME: Best Robert

(a) Residence. No. 3804 E 13th St., 12 Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: 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): 7-22-1924

7. AGE: Years 3 | Months 9 | Days 3 | If LESS than 1 day, ...hrs. or ....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): Missouri

PARENTS
10. NAME OF FATHER: Royal Best
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): K.C. Mo.
12. MAIDEN NAME OF MOTHER: Elizabeth
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Kansas

14. INFORMANT: Ward Clerk
(Address): Kansas City Genl Hosp

15. FILED 4/25, 1928 M. M. Graves
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4-25 1928

17. I HEREBY CERTIFY, That I attended deceased from 4-20, 1928, to 4-25, 1928 that I last saw ~~b~~ alive on 4-25, 1928 and that death occurred, on the date stated above, at 5:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Generalized septicemia
following Scarlet fever
(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?
WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. E. Williams, M. D
4-25, 1928 (Address) Supt K.C. Genl 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: Forest Hill — DATE OF BURIAL: Apr. 26 28
20. UNDERTAKER: Mrs. C. L. Foster — ADDRESS: K.C. 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.

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