

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

Do not use this space.

33683

1. PLACE OF DEATH
 County Sackson Registration District No. 399
 Township Kan Primary Registration District No. 1511
 City Kansas City (No. 1511) 613 22
 File No. _____
 Registered No. 2773
 St. _____ Ward _____

2. FULL NAME Fanni Lewis
 (a) Residence No. 1517 E. 13 St. 2 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 ♀ 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
About 56

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Cook
 (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) ma

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't Know

14. INFORMANT Per Norman (Address) 2352 Frank

15. FILED 10/17 1928 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-15-28

17. I HEREBY CERTIFY, That I attended deceased from 10-10-28 to 10-15-28, 1928, that I last saw him alive on 10-15-28, and that death occurred, on the date stated above, at 10/30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121 Patient Raymond
1029

CONTRIBUTORY Chronic Tuberculosis (duration) yrs. mos. da.
Nephritis (duration) yrs. mos. da.

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) W. L. ... M. D.

1919 (Address) 1617 E 12

*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 Highland Cemetery DATE OF BURIAL 10-17 1928

20. UNDERTAKER W. L. ... ADDRESS 1606 E 18th

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

