

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

Do not use this space.

33692

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City K.C. Mo. (No. 3721 Summit) St. _____ Ward _____
 File No. _____
 Registered No. 282

2. FULL NAME

Dorcas Hinton Todd
 (a) Residence. No. 3721 Summit St., 5 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Frank F. Todd</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan-11-1857</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>9</u>
	DAYS <u>5</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at Home</u> (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) <u>Ky</u>		
PARENTS	10. NAME OF FATHER <u>Gerrill Owen</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Ky</u>	
	12. MAIDEN NAME OF MOTHER <u>Mary Thomas</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Ky</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct, 16, 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1928, to Oct 16, 1928 that I last saw h. s. p. alive on Oct 15, 1928, and that death occurred, on the date stated above, at 6:15 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Loudrip ascending paralysis
810 (duration) yrs. mos. da. 6

CONTRIBUTORY (SECONDARY) no (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 730
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) J. M. Frankelberger, M. D.
10/17, 1928 (Address) 824 Rialto Bldg.

*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 <u>Eminence Ky</u>	DATE OF BURIAL <u>Oct 17, 1928</u>
20. UNDERTAKER <u>Mrs. C. L. Forster</u>	ADDRESS <u>K.C. Mo.</u>

14. INFORMANT Frank F. Todd
 (Address) 3721 Summit

15. FILED 10/17, 28 M. M. Crowe
 REGISTRAR

WRITE PLAINLY, 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.

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