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

Do not use this space.

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1. PLACE OF DEATH
County Jackson — Registration District No. — Primary Registration District No. — File No. — Registered No.
Township Law
City Kansas City (No. Kansas City Gen'l Hosp. St. Ward)

2. FULL NAME McBride Infant

(a) Residence. No. 2711 Tracy St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 7, 1929

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
		3	

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

PARENTS

10. NAME OF FATHER Laurence V. Dell

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

12. MAIDEN NAME OF MOTHER Alice Jane McBride

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

14. INFORMANT Records Clerk
(Address) K.C. Gen'l Hosp.

15. FILED 1-14 1929 M. M. Grace Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-10 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-7, 1929, to 1-10, 1929, that I last saw h[illegible] alive on 1-10, 1929, and that death occurred, on the date stated above, at 8:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity

(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? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clin. Findings

(Signed) P. E. Williamson, M. D.
-10, 1929 (Address) Supt. K.C. Gen. 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	DATE OF BURIAL
Leeds	1/15 1929
20. UNDERTAKER	ADDRESS
[illegible]	915 East 15

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.

1

31

2