

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

Do not use this space.

10564

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City (No. Kansas City Gen Hosp)

Registration District No. 399
Primary Registration District No. 1052

File No. _____
Registered No. 1065
St. _____ Ward _____

2. FULL NAME

Bentelle Infant
(a) Residence. No. General Hospital St. _____ Ward _____
(Usual place of abode) 4145 W. 9th
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) 3-2-29

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 day, 2 hrs. or 25 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Shellis Bentelle

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Northfield, Minn
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Virginis

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

14. INFORMANT Reed Clark
(Address) Kansas City Gen Hosp

15. FILED 7/4, 1929 M. M. Crowe
REGISTRAR Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-3-29

17. I HEREBY CERTIFY, That I attended deceased from 3-2, 1929, to 3-3, 1929, that I last saw him alive on 3-3, 1929, and that death occurred, on the date stated above, at 10:31 a.m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
101A Atelectasis - partial.

CONTRIBUTORY (SECONDARY) Deformity of chest.
(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? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) P. E. Williams, M. D.
74, 1929 (Address) Gen Hosp KC Mo

*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 7/4

UNDERTAKER [Signature] ADDRESS 1912 East 13

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.

RECORD WITH IMPAGING INK—THIS IS A PERMANENT RECORD

