

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

Do not use this space.

10857  
10907

**1. PLACE OF DEATH**

County Jackson Registration District No. 5-5-5  
Township Law Primary Registration District No. 1-6-3  
City Kansas City (No. Kansas City Gen Hosp) :St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1418

**2. FULL NAME**

Scfield Ralph E  
(a) Residence. No. 4208 Woodland 15 Ward. \_\_\_\_\_  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**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) Feb. 19, 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>2</u>	<u>1</u>	<u>3</u>	

**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) Mo

**PARENTS**

10. NAME OF FATHER W. J. Scfield

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

12. MAIDEN NAME OF MOTHER Jessie Rainwater

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

**14.**

INFORMANT Rena Clark  
(Address) Kansas City Gen Hosp

**15.**

FILED 3/22, 1929 M. M. Lawrence  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-22 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-11, 1929 to 3-22, 1929 that I last saw him alive on 3-22, 1929 and that death occurred, on the date stated above, at 3:50 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Epidemic Cerebrospinal meningitis

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Plum & Lab. Findings  
(Signed) P. E. Williams M. D.

3-22-1929 (Address) Supt 72 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**

Mo. Hope 3/23 1929

**20. UNDERTAKER**

**ADDRESS**

O. V. Maest Kans City 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.

