

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

Do not use this space.

18235

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City No. Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 2230
Registered No. 2230
St. _____ Ward)

2. FULL NAME

Frank Maypin
(a) Residence. No. Ashland Hotel St. 1 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unknown

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

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

7. AGE 55 YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

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

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Oyler's (Address) 1800 Linwood

15. FILED 5/17, 1929 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH Monday

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/13 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 3:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured skull
196A
194B

CONTRIBUTORY fall down steps (SECONDARY) rooming house (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? yes
WHAT TEST CONFIRMED DIAGNOSIS autopsy
(Signed) Henry M. Gales, M. D.
5/13, 1929 (Address) Deputy Coroner

*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 Maple Hill DATE OF BURIAL May 24 1929

20. UNDERTAKER Oyler's Funeral Home ADDRESS 1800 Linwood

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.

227
31
31
31

