

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

Do not use this space.

21645
2785

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Keaw Primary Registration District No. 1002
City Kansas City (No. Kansas City Genl Hosp) St. _____ Ward _____

2. FULL NAME

Beck Infant
(a) Residence. No. 906 Main 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 7. 4. COLOR OR RACE W 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) June 25 - 1929

7. AGE YEARS MONTHS DAYS ✓ ✓ ✓ ✓
IF LESS than 1 day, 60 hrs. or 35 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) Genl Hosp
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Earl Coff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) W. Union
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Mary Beck

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Blue Grass
(STATE OR COUNTRY) Iowa

14. INFORMANT Reverend Clerk
(Address) K.C. Genl Hosp

15. FILED 6/25/29 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-24 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-24 1929, to 6-24 1929, and that I last saw him alive on 6-24 1929, and that death occurred, on the date stated above, at 10:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity (6 months)
159

CONTRIBUTORY (SECONDARY) 161W
(duration) _____ yrs. _____ mos. _____ ds.

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.

6-25-1929 (Address) Subst K.C. Genl 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 Leeds DATE OF BURIAL 6-27 1929

20. UNDERTAKER [Signature] ADDRESS 1916 East 15

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.

