

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

Do not use this space.

27747
3437

1. PLACE OF DEATH

County Jackson
Township K.C. East
City K.C. Mo.

Registration District No. 399
Primary Registration District No. 1002

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

2. FULL NAME

(a) Residence. No. 3101 E 11th St. 12 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 (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 9, 1929
7. AGE YEARS MONTHS DAYS 6 mo 29 If LESS than 1 day, _____ hrs. or _____ min.

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) Kansas City (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Abraham S. Batrick
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Syria (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Julia Harris
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Mo.

14. INFORMANT Information given by Mr. Batrick (Address) per T. Delphond - Mercy St.

15. FILED 8/12/29 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-8 1929

17. I HEREBY CERTIFY, That I attended deceased from 8-6 1929, to 8-8 1929 that I last saw him alive on 8-8 1929, and that death occurred, on the date stated above, at 10:20 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Aplasia

CONTRIBUTORY (SECONDARY) Inanition (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 15902 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. M. Smith, M. D.
8/9 1929 (Address) Angels Bldg

*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 St. Marys DATE OF BURIAL 8-10 1929

20. UNDERTAKER Mrs. Ed. Foster ADDRESS City

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

