

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

Do not use this space.

30883

1. PLACE OF DEATH

County Jackson
Township Keokuk
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 3907
Registered No. 3907
Ward

2. FULL NAME

Frances Todd
(a) Residence. No. 1411 Madison St. Ward 1
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) April 20-1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>1</u>	<u>4</u>	<u>23</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Infant 99A
(b) General nature of industry, business, or establishment in which employed (or employer). 123D
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Thomas Todd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Evelyn Kunyon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Iowa

14. INFORMANT The ward Clerk
(Address) Kansas City, Genl Hosp

15. FILED 9/16, 1929 M. M. Crozier
REGISTRAR Amr

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-13 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-29 1929, to 9-13 1929, that I last saw him alive on 9-13 1929, and that death occurred, on the date stated above, at 5:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bilateral Otitis Media
following Whooping Cough

CONTRIBUTORY (SECONDARY) acute degeneration of
abdominal viscera

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 clin. find & Autopsy
(Signed) P. B. Weese M. D.
14, 19 29 (Address) Supt. 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 Highland Park DATE OF BURIAL 9-16 1929

20. UNDERTAKER O V Mast ADDRESS 1915 E 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.

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