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

Do not use this space.

34072 a

34072-a

File No. 34072

Registered No. 339

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: K C Mo (No. General Hospital #2 St. Ward)
Registration District No.
Primary Registration District No.

2. FULL NAME: Robert Dumas
(a) Residence. No. 1007 E 16th St. St., 4 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. 55 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
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) Aug 30 1929

7. AGE: Years | Months 1 | Days 25 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby no
(b) General nature of industry, business, or establishment in which employed (or employer): occupation
(c) Name of employer

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

PARENTS
10. NAME OF FATHER: Joe Dumas
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Okla.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Johnetta Mathews
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kansas.

14. INFORMANT File Clerk
(Address) General Hosp. #2

15. FILED 2/18, 1930 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 25 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-8-29, 19..., to 10-25-29, 19..., that I last saw h. alive on 10-25-29, 19..., and that death occurred, on the date stated above, at 10-25-29 8.50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital Syphilis
(duration) yrs. mos. 55 ds.
CONTRIBUTORY (SECONDARY) Malnutrition
Since birth (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? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) H O Smith, M. D.
10/26, 1929 (Address) Old City 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: Leed Farm
DATE OF BURIAL: Feb 19 1930

20. UNDERTAKER: West Appleton & Jones
ADDRESS: 1600 E 19

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