

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

Do not use this space.

37153

4622

1. PLACE OF DEATH

County Jackson
Township Kaw
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. 1017 E. 16th St. St. _____ Ward. 4

Length of residence in city or town where death occurred 1 yrs. 8 mos. da. 4 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) 2-29-28

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>1</u>	<u>8</u>	<u>8</u>	<u>8</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Babysat home
(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 William Abernathy

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

12. MAIDEN NAME OF MOTHER Thompson V.

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

14. INFORMANT File Clerk Wm Abernathy
(Address) 1017 E 16th St.

15. FILED 11/9, 1929 M. M. Crowe
asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-7-29

17. I HEREBY CERTIFY, That I attended deceased from 11-2-29 to 11-7-29, 19____, that I last saw heart alive on 11-7-29, 19____, and that death occurred, on the date stated above, at 6 p.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inanition Fever

2006-4 (duration) yrs. 1 mos. ds.
CONTRIBUTORY (SECONDARY) 160 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH K.C. Mo

(i) DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) H. M. Smith, M. D.

1117 1929 (Address) K.C. Gen Hosp # 2
*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 Cem. DATE OF BURIAL NOV-9 1929

20. UNDERTAKER Roberts Bros ADDRESS 2000 E. 12

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.

PARENTS

