

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

Do not use this space.

37176

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1009 Registered No. 4645
 City Kansas City (No. K. C.) General Hosp St. _____ Ward _____

2. FULL NAME

Frank C. Bates
 (a) Residence No. 1246 Broadway St. 1 Ward. _____ (If nonresident, give city or town and State)
 (Usual place of abode)
 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 Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Inventor
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) _____

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known (STATE OR COUNTRY) _____

14. INFORMANT Record Clerk (Address) F. C. General Hosp

15. FILED 11-29-29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 1929

17. Ceroney
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of skull
1925
Cause unknown
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 2010
 (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? yes

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) Wm. Carbaugh M. D. _____, 1929 (Address) Ceroney

*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 Wash Hill DATE OF BURIAL 11-13-1929

20. UNDERTAKER J. F. Lewis ADDRESS K.C. Mo.

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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PARENTS

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