

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

Do not use this space.

1463

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Jean Primary Registration District No. 1002  
 City Kansas City (No. Kansas City Genl Hosp) (State Mo) (Ward)

File No. \_\_\_\_\_

Registered No. 456

**2. FULL NAME**

(a) Residence. No. General Hosp Ward. \_\_\_\_\_  
 (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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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) Jan 26 1930

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. of mins.  
15 yrs. 1 hrs. 15 mins.

**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) General Hosp  
 (STATE OR COUNTRY) Kansas City Mo

10. NAME OF FATHER Charles Clements

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

12. MAIDEN NAME OF MOTHER Mary Meers

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

14. INFORMANT Reverend Clerk  
 (Address) K.C. General Hosp

15. Jan 31 1930 M. M. Crowe  
 FILED REGISTRAR Amk

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-26 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-26 1930 to 1-26 1930, that I last saw him alive on 1-26 1930 and that death occurred, on the date stated above, at 6:00 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Prematurity  
159 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 16/10  
 (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? Autopsy

(Signed): P. E. Williamson, M. D.

-29 (Address) Subst 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 Seeds DATE OF BURIAL 1-30-30

20. UNDERTAKER O. U. Mast 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.

