

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

Do not use this space.

4878

527

1. PLACE OF DEATH

County Jackson Registration District No. 328
 Township Law Primary Registration District No. 10
 City Kansas City (No. Kansas City General Hosp) Ward

File No. _____
 Registered No. _____

2. FULL NAME

Elsie McKenzie
 (a) Residence. No. William Mo St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2 1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
23 8 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Line man
 (b) General nature of industry, business, or establishment in which employed (or employer). _____
 (c) Name of employer K.C. P. & L. Co.

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

10. NAME OF FATHER Wm. S. McKenzie
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Michigan
 12. MAIDEN NAME OF MOTHER Florida Buckler
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Deena Clark
 (Address) K.C. General Hosp

15. FILED 14 1930 M. M. Groves REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-4 1930 to 2-4 1930 that I last saw him alive on 2-4 1930 and that death occurred, on the date stated above, at 12:00 noon

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic cerebro spinal meningitis

18 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 24 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Genital findings
 (Signed) P. B. Williams M. D.
2-4 1930 (Address) Supt K. C. Gen. 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 William Mo DATE OF BURIAL 4 1930

20. UNDERTAKER O. Mast ADDRESS 1915 East 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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