

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

Do not use this space.

4986

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Faw Primary Registration District No. 1002
City Kansas City (No. St. Lukes Hospital)

File No. _____
Registered No. 341
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 6941 Prospect 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
5 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(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 Strother Lawrence

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

12. MAIDEN NAME OF MOTHER Blande Brewer

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

14. INFORMANT Mr. Lawrence
(Address) Above

15. FILED 7/11 1930 M. M. Groves REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 6 1930

17. I HEREBY CERTIFY, That I attended deceased from 2
6 1930, to same 19.....
that I last saw him alive on same 19....., and that
death occurred, on the date stated above, at 8
P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis (Clinical 89A
diagnosis) Negative 79A
spinal fluid findings
(duration) ____ yrs ____ mos ____ ds.

CONTRIBUTORY None Otitis Media
(SECONDARY) (duration) ____ yrs ____ mos ____ ds.

18. WHERE WAS DISEASE CONTRACTED 8/6/29
IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? not permitted
WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. M. Gilbey M. D.
7/6 1930 (Address) Mersey Hosp. DR. DAVIS

*State the DISEASE CAUSING DEATH, or 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 Raymore Mo. DATE OF BURIAL 7/8 1930

20. UNDERTAKER E. J. George & Sons ADDRESS Belton

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.

