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

Do not use this space.

5303-a

1. PLACE OF DEATH
County Jackson
Township Sun
City Kansas City Mo (No. General Hosp #2 St. Ward)
Registration District No. 399
Primary Registration District No. 1002
File No. 1
Registered No. 1702

2. FULL NAME Morehead Elizz
(a) Residence. No. 560 Front St., 1 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 27 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 Negro
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) Unknown
7. AGE Years 50 Months — Days — If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
14. INFORMANT Record Clerk
(Address) City Hospital #2
15. FILED 4/18, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27 1930
17. I HEREBY CERTIFY, That I attended deceased from 2-20-30, 19..., to 2-27-30, 19..., that I last saw him alive on 2-27-30, 19..., and that death occurred, on the date stated above, at 10 40 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
(1) Septicemia
(2) Gangrene of foot and leg Due to Frost bite
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 36 (duration) yrs. mos. ds.
1516
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF 2-20-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. M. Smith, M. D.
7/28, 1930 (Address) City Hospital #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 Leeds Mo
DATE OF BURIAL 4-22 1930
20. UNDERTAKER H. B. Moore
ADDRESS 1820 E 18th

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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