

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

Do not use this space

BA

5330

File No. _____
Registered No. *7* St. _____ Ward)

1. PLACE OF DEATH

County *Jackson* Registration District No. *404*
Township *Washington* Primary Registration District No. *5558*
City *K.C. Mo* (No. _____ St. _____ Ward)

2. FULL NAME

Infant Stout
(a) Residence. No. *8122 Woodland* 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 *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 2 1930*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, *6* hrs. or *12* min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *K.C. Mo*
(STATE OR COUNTRY) *Mo*

PARENTS
10. NAME OF FATHER *Calvin Stout*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Rock Springs*
(STATE OR COUNTRY) *Mo*
12. MAIDEN NAME OF MOTHER *Merna May Porter*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Lathrop Mo*
(STATE OR COUNTRY) *Mo*

14. INFORMANT *S. W. Fair*
(Address) *7308 Washington*

15. FILED *25* 19*30* J. *B. B. Brimmer* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 2 1930*
17. I HEREBY CERTIFY, That I attended deceased from *Feb 2* 19*30*, to *Feb 2* 19*30* that I last saw her alive on *Feb 2* 19*30*, and that death occurred, on the date stated above, at _____ A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
About 6 hrs (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *159* (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? *no*
WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *S. W. Fair* M. D.
2/2, 1930 (Address) *7308 Washington*

*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 *Lathrop Mo* DATE OF BURIAL *Feb 3 1930*

20. UNDERTAKER *R. V. Lindsey* ADDRESS *Law City*

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.

MAR 27 1930

