APR 30 1930

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

Do not use this space.

1. PLACE OF DEATH

County: Lafayette — Registration District No. 460 — File No. 5516

Township: — Primary Registration District No. 4274 — Registered No. 29

City: Higginsville, (No. ..... St. ..... Ward)

2. FULL NAME " Baby " McGinnis

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 13th 1930

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, 3 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Higginsville,
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER J. L. McGinnis

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

12. MAIDEN NAME OF MOTHER Sophie Lees

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

14. INFORMANT [signature]
(Address) Higginsville, Mo.

15. FILED 2-14, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby 13th 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-3-, 1930, to 2-3-, 1930 that I last saw him alive on 2-3-, 1930, and that death occurred, on the date stated above, at 2 hrs after Birth a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Do Not Know he only lived about 2 hours. Respiration labored & similar to Chain Stroke Respiration
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
(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? No Diagnosis
(Signed) [signature], M. D
, 19 (Address) Higginsville Mo

*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: City Cemetary — DATE OF BURIAL: 2/14/ 1930

20. UNDERTAKER: Higginsville, Mo. [signature] — ADDRESS: Higginsville Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.