

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

Do not use this space.

8594

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 1002 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 2004 N. 1st St. \_\_\_\_\_ Ward. Kan. City, Kans.  
(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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 7 1928

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

|   |   |   |  |
|---|---|---|--|
| 1 | 7 | ? |  |
|---|---|---|--|

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

9. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER Frazier, Henry

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

12. MAIDEN NAME OF MOTHER Bell, Lilly

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

14. INFORMANT Record clerk  
(Address) Gen. Hosp. No. 2

15. FILED 3/30 M. M. Crowe REGISTRAR  
osil

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to Mar 2, 1930 that I last saw h. in alive on March 2, 1930, and that death occurred, on the date stated above, at 6:20 P. m.

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

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

CONTRIBUTORY (SECONDARY) 24 (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? Bacteriological  
(Signed) Howard M. Smith M. D.  
3-2-1930 (Address) Gen. Hosp. No. 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 West Lawn DATE OF BURIAL Mar 3, 1930

20. UNDERTAKER W. W. Thatcher ADDRESS 1520 North G. Kansas

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.

