

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

Do not use this space.

8663

1. PLACE OF DEATH

County Jackson
Township Kan.
City Kansas City Mo.

Registration District No. 359

Priority Registration District No. 1007

City Geny Hosp #2

File No. _____
Registered No. 11210
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1121 Independence Ward 1
(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 Fe 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 9-1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 0 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work
(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) Texas

10. NAME OF FATHER Henry Pratt

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

12. MAIDEN NAME OF MOTHER Leitee Ink

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

14. INFORMANT Mary Fields
(Address) 1121 Independence Av

15. FILED 3-8-30 M. M. Crome REGISTRAR
asst

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-20 30 1930, to 2-5 30 1930, and that that I last saw him alive on 2-5-30 and that death occurred, on the date stated above, at 12 midnight

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dementia Praecox
etc. Myocarditis
(duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 93C
70B (duration) 84 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) [Signature], M. D.

315 (Address) General Hosp #9
*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 Bluff Ridge Lawn 1930
DATE OF BURIAL _____
20. UNDERTAKER Wattson Bros ADDRESS 129 Lydia

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.

23.0

