

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

Do not use this space.

12848

1. PLACE OF DEATH

County Jackson

Registration District No. 397

Township Kaw

Primary Registration District No. 3052

City Kansas City

(No. Kansas City Genl Hosp)

File No. _____

Registered No. 1777

St. _____ (Ward)

FULL NAME John Robertson Drake

(a) Residence. No. 505 Delaware St. 1 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 1 mos. 1 da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
36 4 10

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

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

10. NAME OF FATHER John Drake

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

12. MAIDEN NAME OF MOTHER Idia Dickson

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

14. INFORMANT De wald Clark
(Address) K.C. General Hosp.

15. FILED 4/23 1930 M.M. Carrow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-22 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 4-22, 1930, that I last saw him alive on 4-22, 1930, and that death occurred, on the date stated above, at 3:46 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
2.3A

(duration) _____ yrs. _____ mos. _____ ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chem + Gal. Found

(Signed) P.B. Williams, M.D. 4-22 1930 (Address) Subst 7 C. Genl Hosp

*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 Forest Hill DATE OF BURIAL 4/23 1930

20. UNDERTAKER H. Bergman ADDRESS Kansas City, Mo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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