

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

Do not use this space.

16216

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City (No. Kansas City 2nd 9th)

Registration District No. 399
Primary Registration District No. 2992

File No. _____
Registered No. 2120
St. _____ Ward _____

2. FULL NAME

Hallock William

(a) Residence. No. 328 S. Brighton St. 10 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-20-1884

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>46</u>	<u>3</u>	<u>28</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(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) Missouri

10. NAME OF FATHER

B. J. Hallock

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

Schaack

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

14. INFORMANT

Recard L. Lark
(Address) Kansas City 2nd 9th

15. FILED

5/18 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-18-1930

17. I HEREBY CERTIFY, That I attended deceased from 5-18-1930, to 5-18-1930, that I last saw him alive on 5-18-1930, and that death occurred, on the date stated above, at 2:00 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic cerebrospinal meningitis

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? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. E. Williams, M. D.
5-18 1930 (Address) Dept. K. B. Gen. 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

DATE OF BURIAL

Highland Park Cem May 19 1930

20. UNDERTAKER

ADDRESS

Daniels Bros 624 Kansas
ave. K. C.

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.

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