

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

Do not use this space.

16231

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 21340
St. _____ Ward _____

2. FULL NAME

Robert Prather
(a) Residence. No. 4235 Virginia St. 15 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) May 25-1921

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 11 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy
(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) Mo

PARENTS

10. NAME OF FATHER Clarence Prather

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

12. MAIDEN NAME OF MOTHER Irene Smith

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

14. INFORMANT

Reverend Clerk
(Address) Kansas City Gen Hosp

15. FILED

5/19/20 M. M. Crave
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-19 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-19, 1930 to 5-19, 1930 that I last saw him alive on 5-19, 1930 and that death occurred, on the date stated above, at 2:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic Cerebro spinal 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? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Clinical & med. autopsy

(Signed) P. E. Williams, M. D.
5-19, 1930 (Address) Supt KC 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

Forest Hill 5/20 1930

20. UNDERTAKER

ADDRESS

Wm C L Forster KC Mo

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.

