

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

Do not use this space.

26710

**1. PLACE OF DEATH**

County Jackson Registration District No. 399

Township Paris Primary Registration District No. 7602

City Kennett (No. Kennett 1st Sup.) St. 3314 (Ward)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Harriet Infant (twin) St. \_\_\_\_\_ 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)**

8-9-30

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, 5 hrs. or 30 min.

**8. OCCUPATION OF DECEASED**

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

Child

(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)

Kennett Mo  
Missouri

**10. NAME OF FATHER**

Jack Harriet

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo

**12. MAIDEN NAME OF MOTHER**

Marjorie Williams

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Kennett Mo  
Missouri

**14. INFORMANT**

(Address)

Reverend Albert  
Kennett City 3rd St. Hosp.

**15. FILED**

8/10/30

M. M. Crowe  
asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

8-9-1930

**17.**

I HEREBY CERTIFY, That I attended deceased from

8-9-1930, to 8-9-1930

that I last saw him alive on 8-9-1930, and that death occurred, on the date stated above, at 7:15 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Prematurity  
159

**CONTRIBUTORY (SECONDARY)**

161A

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

**19. DID AN OPERATION PRECEDE DEATH?**

DATE OF \_\_\_\_\_

**20. WAS THERE AN AUTOPSY?**

yes

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed)

P. E. Williams M. D.

8-10-1930 (Address) Sup't A. B. Gen'l. 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**

Leeds Cemetery

August 11 1930

**20. UNDERTAKER**

John J. Sheehan

**ADDRESS**

K. E. Mo

K. E.—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.

Company Name ( )