

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

Do not use this space.

26874

3487

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Jean Primary Registration District No. _____
City Kansas City (No. K.C. Genl Hosp) St. _____ Ward _____

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

2. FULL NAME Breckmead Jr Inf

(a) Residence. No. Gen. Hosp. St. _____ Ward _____
(Usual place of abode)

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

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) 8-19-30

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
			<u>4</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Leonard Breckmead Jr

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

12. MAIDEN NAME OF MOTHER Hazel McClain

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

14. INFORMANT Reinald Clark
(Address) K.C. Genl Hosp

15. FILED 8-23-1930 M. M. Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-19, 1930 to 8-23, 1930
that I last saw her alive on 8-23, 1930 and that death occurred, on the date stated above, at 1:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity (Twin)
159
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 1610
(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. Williams, M. D.
8-23, 1930 (Address) Subt K.C. 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 Highland Park DATE OF BURIAL Aug 23 1930

20. UNDERTAKER John J. Schuman ADDRESS G. C. 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.

