

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

Do not use this space.

30161

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. 3723 Bell)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 3069
St. _____ Ward _____

2. FULL NAME

Hiram J. Prather
(a) Residence. No. 3723 Wab. St. 13 Ward _____

(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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Florence B. Prather

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 20, 1888

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day,hrs. ormins.
	<u>48</u>	<u>0</u>	<u>8</u>	

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

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

10. NAME OF FATHER Willis M. Prather

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

12. MAIDEN NAME OF MOTHER Pamela Alford

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

14. INFORMANT Florence B. Prather
(Address) 3723 Wabash

15. FILED 9/29/30 M. M. Crowe
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1930

17. I HEREBY CERTIFY, That I attended deceased from 9/28 8:00 to 9/28 8:00 that I last saw him alive on 9/28/30 12:00 and that death occurred, on the date stated above, at 7:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion
118C
95B
112C (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) same as above
support above (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Acute Indigestion Heart

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) O. Conradson M. D.

(Address) 3922 Bell

*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 Mt. Washington DATE OF BURIAL Sept. 30, 1930

20. UNDERTAKER Eyles Funeral Home ADDRESS K.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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson

Registration District No.

File No.

Township Kew

Primary Registration District No.

Registered No. 2969

City Keokuk (No. 3923)

Bell St

St. Ward)

2. FULL NAME

(a) Residence. No. 3723 Bell St., Ward.

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

48

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 9/29/30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-28 19 30

17.

I HEREBY CERTIFY That I attended deceased from

that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Indigestion
some food, he had
eaten for his evening meal
acute dilatation of
heart

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)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

N. S. B. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1930

30161.