

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

Do not use this space.

33001

4231

PLACE OF DEATH

County Jackson Registration District No. 399
 Township Blue Primary Registration District No. 1002
 City Reeds K.C. MO (No. 71013 / Hospitals)

File No. 4231
 Registered No. _____
 St. _____ Ward _____

FULL NAME

(a) Residence. No. Bell Walter St. 4 Ward. _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-16-1930

6. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single

17. I HEREBY CERTIFY, That I attended deceased from 9-23-1930, to 10-16-1930, that I last saw him alive on 10-16-1930, and that death occurred, on the date stated above, at 1:25 P.M.

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30-1905
 AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 0 16

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pulmonary Tuberculosis

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

9. CONTRIBUTORY (SECONDARY) 51 (duration) over 1 year yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Nashville Tenn
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH unknown

10. NAME OF FATHER Bell Robert

11. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

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

12. WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Frierson Catherine

13. WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Laboratory
 (Signed) Walter A. Sherman M. D.
out 17, 1930 (Address) 733 Reeds Bldg
15th & Olive Sts

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

*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.

INFORMANT K.C.T.B. Hospital
 (Address) 900 Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland Cemetery DATE OF BURIAL 10-18-30

FILED 10-18-30 mon Crowe REGISTRAR

20. UMBERTAKER Wm. A. V. Fickler ADDRESS 1217 Vine

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