

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

Do not use this space.

39537
- 2130

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kan Primary Registration District No. _____
 City Kansas City (No. General Hospital) St. _____ Ward _____

2. FULL NAME

Franklin Ray
 (a) Residence. No. 272 Mills 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 m 4. COLOR OR RACE w 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) June 18 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
34 5 28

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

9. BIRTHPLACE (CITY OR TOWN) Winnetago
 (STATE OR COUNTRY) Minnesota

10. NAME OF FATHER Phillip Franklin

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

12. MAIDEN NAME OF MOTHER Ida May Hurd

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

14. INFORMANT Records Clerk
 (Address) K. G. General Hosp

15. FILED 12/20 1930 M. M. Cravel
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-17 1930 to 12-19 1930 that I last saw him alive on 12-19 1930, and that death occurred, on the date stated above, at 11:40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic Cerebro spinal meningitis
18 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

7 (Signed) P. E. Williams, M. D.

12 1930 (Address) Gen Hosp K C Mo

*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

Maple Hill - Kan city Kan 12-20 1930

20. URBERTAKER ADDRESS

John J. Sheehan K C 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.

