

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

Do not use this space.

39565

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 4125 Mercier)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 10458
St. _____ Ward _____

2. FULL NAME Frank A. Makinson

(a) Residence No. 4125 Mercier St. 7 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) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Orry Makinson				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 1858				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	72	8	6	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Stationary Engineer (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) **Iowa**

PARENTS	10. NAME OF FATHER Thomas Makinson
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Indiana
	12. MAIDEN NAME OF MOTHER Sarah Finley
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

14. INFORMANT **Mrs Orry Makinson**
(Address) **4125 Mercier**

15. FILED 12/22 1930 M. M. Cronin REGISTRAR
W. S. T.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec. 20, 1930**

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1930 192 to Dec 20 1930 1930 that I last saw him alive on Dec 19 1930 and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
A fatal strain
of the brain
due to
103A Coronary thrombosis
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Syngian
(Signed) B. E. ... M. D.

1930 (Address) 676 ...
*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 Moriah Cemetery** DATE OF BURIAL **12-23-30**

20. UNDERTAKER **R. V. Lindsey & Sons, Inc.** ADDRESS **City**

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr. A. T. Stamp