

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

Do not use this space.

39579

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas

Registration District No. _____
Primary Registration District No. _____
(No. Gen Hosp. No 2)

File No. 5050
Registered No. _____
St. O.B. Ward

2. FULL NAME

Infant Cornelia Garrett
(a) Residence. No. General Hospital #2, O.B. 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. 6 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>—</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>12-15-30</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> (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

Eunice Lee Thomas
1019 Virginia

1/23 1930 M. M. Connor
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-15 1930 to 12-21 1930 that I last saw him alive on 2/3 1930, and that death occurred, on the date stated above, at 9:40 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Starvation and Marasmus
158 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH General Hospital #2

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. M. Muller, M.D.
1/22, 1930 (Address) General Hospital #2

*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

Blue Ridge Lawn 12-23 1930

20. UNDERTAKER

ADDRESS

West Capital & Jones 1600 E 19

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—IRIS IS A PERMANENT RECORD

