

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

Do not use this space.

461

1628

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Beau Primary Registration District No. _____
 City Kansas City (No. Kansas City Genl Hosp St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 720 Genl Hosp St. Ward. _____
 (Usual place of abode) 220 S. Lehigh (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. _____ mos. 21 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</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>infant</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 11, 1931</u>		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.
		<u>21</u>

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

9. BIRTHPLACE (CITY OR TOWN) JC Genl Hosp
 (STATE OR COUNTRY) Kansas City, Mo.

PARENTS	10. NAME OF FATHER <u>Addison A. Aiken</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>J.C.</u> (STATE OR COUNTRY) <u>Mo</u>
	12. MAIDEN NAME OF MOTHER <u>Berna Myers</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo</u>	

14. INFORMANT Record Clerk
 (Address) JC Genl Hosp

15. FILED 1/31/31 M. M. Cray
 REGISTRAR 1221

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1931 to Jan 31, 1931 that I last saw him alive on Jan 31, 1931, and that death occurred, on the date stated above, at 1:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity

159
159 (duration) _____ yrs. _____ mos. _____ ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) R. B. Williams, M. D.
1-31-31 (Address) Subt JC Genl Hosp

*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 Union Cemetery DATE OF BURIAL 1-31-1931

20. UNDERTAKER Stine & M. O. Chase ADDRESS 3235 William Plaza

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.

