

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

Do not use this space.

37905

1. PLACE OF DEATH

County Jackson Registration District No. 302
 Township Kan Primary Registration District No. 100
 City Kansas City (No. General Hospital) St. _____ Ward)

2. FULL NAME

Erickson Infant
 (a) Residence, No. General Hospital Ward.
 (Usual place of abode) 214 Harrison (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) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-26-31
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, 5 hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Harry Erickson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Mary Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT (ADDRESS) Record Clerk R. C. General Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Heads DATE 11-30-31

19. UNDERTAKER (ADDRESS) Walter B. Kapelina R. C. Gen Hosp

20. FILED 11-29 19 31 M. D. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-26 1931

22. I HEREBY CERTIFY, That I attended deceased from 11-26, 1931, to 11-26, 1931

I last saw him alive on 11-26, 1931. Death is said to have occurred on the date stated above, at 5:45 a.m.

The principal cause of death and related causes of importance were as follows:

Prematurity
159 159

Date of onset _____
 Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

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

(Address) Gen Hosp R. C. M.D.

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.

