

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

Do not use this space.
1376

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Law Primary Registration District No. 1002
City Kansas City (No. Gen. Hosp. #2)

File No. ERC
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Frankie Hurt
(a) Residence. No. 621 Harrison St., _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>negro</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>Baby</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan. 25 - 1929</u>		
7. AGE <u>2</u>	YEARS <u>2</u>	MONTHS <u>4</u>
	DAYS <u>4</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> <u>23A</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>69B</u> (c) Name of employer		

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

PARENTS	10. NAME OF FATHER <u>Clark Hurt</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>N.Y.</u> <u>2</u>
	12. MAIDEN NAME OF MOTHER <u>Hattie Coleman</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>MO.</u> <u>1</u>	

14. INFORMANT Record Clerk
(Address) Gen Hosp. #2

15. FILED 2/13/32 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-29 1932

17. HEREBY CERTIFY, That I attended deceased from 23 _____, 1932, to 1-29 _____, 1932, that I last saw her alive on _____, 1932, and that death occurred, on the date stated above, at 1:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

tuberculosis of st. hip and lungs

CONTRIBUTORY (SECONDARY) Openid
(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 lab. xray ad clinical
(Signed) D.M. Miller, M.D.
, 19 _____ (Address) Gen. Hosp. #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 <u>Weston, Missouri</u>	DATE OF BURIAL <u>Feb. 14 1932</u>
20. UNDERTAKER <u>West, Appleton & Jones</u>	ADDRESS <u>1600 E. 19th St</u>

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.

