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

Do not use this space.

APR 25 1934

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.: 9205
Township: — Primary Registration District No.: 1603 — Registered No.: 1404
City: Kansas City Mo. (No.: Akeside Hospital St.: Ward:)

2. FULL NAME: Baby Henry
(a) Residence. No.: 4512 Charlotte 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: American
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): March 27 1934
7. AGE: Years | Months | Days | If LESS than 1 day, 7 hrs. or 14 min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Kansas City Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: William R. Henry
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Fairfax
(STATE OR COUNTRY): Oklahoma
12. MAIDEN NAME OF MOTHER: Allum Hoppers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Gallion
(STATE OR COUNTRY): Missouri

14. INFORMANT: Wm. R. Henry
(Address): 4512 Charlotte
15. FILED: Mch 29, 1934 M. M. Grove
Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 27 1934
17. I HEREBY CERTIFY, That I attended deceased from Mch 27, 1934, to Mch 27, 1934, that I last saw h. alive on Mch 27, 1934, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed): Roy Young M.D.
, 19 (Address) 253-4 Werby Bldg

*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: Bolivar Mo — DATE OF BURIAL: B-28 1934
20. UNDERTAKER: Family — ADDRESS:

Use black ink. Write plainly. Do not use abbreviations, or unit it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state