

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City Mo (No. Research Hospital)

Registration District No. 399  
Primary Registration District No. 1002

File No. 5891  
Registered No. 23  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 326 North St., Topping 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 <u>Girl</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>None</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Stillborn</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Infant</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>None</u>	
	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) <u>Kansas City Missouri</u>	13. NAME <u>William R. Byfield</u>	
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Woodson County Kansas</u>	
MOTHER	15. MAIDEN NAME <u>Kathryn M. Albright</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clarence Missouri</u>	
17. INFORMANT <u>William R. Byfield</u> (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Research Lab</u> DATE _____ 19__		
19. UNDERTAKER (ADDRESS)		
20. FILED <u>7/17</u> 19 <u>38</u> <u>M. M. Brown</u> Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 11, 1938

22. I HEREBY CERTIFY, That I attended deceased from July 11, 1938 to July 11, 1938

I last saw h. at home, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Anaerobic Infection Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Delayed uterine development  
Hydroaeriosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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) Stan J. Chang M. D.  
(Address) 1107 Broadway Bldg

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.

