REC'D APR 25 1939

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

Do not use this space.
9814
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1. PLACE OF DEATH
County Jackson
Township Kaw
City K. C. Mo. (No. General Hospital #2 St. ..... Ward)
Registration District No. 399
Primary Registration District No. 1002
File No. .....
Registered No. .....

2. FULL NAME 452 Infant Williams
(a) Residence, No. General Hospital #2 St. ..... 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 Female
4. COLOR OR RACE Colored
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) 3-6-1939
7. AGE YEARS — MONTHS — DAYS 0 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. — None
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) Mo

FATHER
13. NAME Williams
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk

MOTHER
15. MAIDEN NAME Mary Kitchen
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Record Clerk General Hosp.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Leeds Cemetery DATE 3/24 1939
19. UNDERTAKER (ADDRESS) West Appleton & Jones Inc 1908 Vine
20. FILED Mch 9 1939 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-6, 1939
22. I HEREBY CERTIFY, That I attended deceased from 3-6, 1939, to 3-6, 1939
I last saw her alive on 3-6, 1939. Death is said to have occurred on the date stated above, at 6:15 P.M.
The principal cause of death and related causes of importance were as follows:

Still Born (Macerated)

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? ..... [illegible]

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) J. C. Turner, M. D.
(Address) General Hospital #2

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.

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