

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

File No. 5028

Township How

Primary Registration District No. 1002

Registered No. 5028

City Kansas City

(No. Kansas City General Hosp) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Alvin Frank W.

(a) Residence. No. 407 Locust St. 1 Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5 - 1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>50</u>	<u>11</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Truckster

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Indiana

**10. NAME OF FATHER**

John Alvin

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Indiana

**12. MAIDEN NAME OF MOTHER**

not known

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Indiana

**14.**

INFORMANT Record Clerk  
(Address) K.C. General Hosp.

**15.**

FILED 7/16 28 M.M. Lesone REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-15 1928

17. I HEREBY CERTIFY, That I attended deceased from 12-22, 1927 to 2-15, 1928 that I last saw him alive on 2-15, 1928, and that death occurred, on the date stated above, at 8:25 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Hypertatic Broncho-pneumonia  
1000 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY Old Ventral Hernia  
(SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 12-30-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clyfax and Grams  
(Signed) P.E. Williams, M. D.

2-15, 1928 (Address) Subt K.C. Genl Hosp.

\*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**

Maple Hill

**DATE OF BURIAL**

2-17 1928

**20. UNDERTAKER**

O. U. Mast

**ADDRESS**

1915-E-15

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.

