

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

Do not use this space.

13622

**1. PLACE OF DEATH**

County Jackson  
Township Osaw  
City Kansas City (No. 7 C. General Hosp)

Registration District No. 399  
Primary Registration District No. 1092

File No. \_\_\_\_\_  
Registered No. 1961  
SL \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wilson Infant

(a) Residence. No. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) General Hosp (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 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) 4-16-28

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_hra. or \_\_\_\_\_min. 12

**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) Ke mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Francis Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dixon Ill  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Julia Carlton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Buffalo Wyoming  
(STATE OR COUNTRY)

14. INFORMANT Reuders  
(Address) K.C. Genl Hosp

15. FILED 5/2 28 M. M. Brown REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28 1928

17. I HEREBY CERTIFY That I attended deceased from 4-16, 1928, to 4-28, 1928 that I last saw her alive on 4-28, 1928, and that death occurred, on the date stated above, at 8:30 a.m.

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

Prematurity  
159  
16/00  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. mos. da.

**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? \_\_\_\_\_

(Signed) P. E. Williams, M. D.  
4-28, 1928 (Address) Subst 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 Leeds. DATE OF BURIAL 4-30 1928

20. UNDERTAKER O. V. Mast ADDRESS \_\_\_\_\_

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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jackson  
Township R City  
City R City (No. ....)

Registration District No. 399  
Primary Registration District No. 1002

File No. ....  
Registered No. 1961  
St. .... Ward

**2. FULL NAME**

(a) Residence. No. ..... 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 5/2 19 28 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr - 28 19 38

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. .... mos. .... ds.  
..... (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)....., M. D.

, 19 (Address)

\*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Klo Mo

**SUPPLEMENTARY**

PERMANENT RECORD

EXACTLY. PHYSICIANS should state OCCUPATION is very

COMPLETE AS PRESCRIBED BY LAW

UNFADING INK---TH

carefully supplied. AGE at CAUSE OF DEATH in plain

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL

WRITE PL

Every item of info

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