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

Do not use this space.

30449

2697

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. .....

Township Kaw — Primary Registration District No. ..... — Registered No. .....

City Kansas City (No. Kansas City Genl Hosp. St. ..... Ward)

2. FULL NAME Mol Infant

(a) Residence. No. 1927 College 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-1-28

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 3 hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work New Born Infant

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) General Hosp.
(STATE OR COUNTRY) Kansas City, Mo.

PARENTS

10. NAME OF FATHER Peter Mol

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

12. MAIDEN NAME OF MOTHER Jennie Kelly

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

14. INFORMANT Record Clerk
(Address) Kansas City Genl Hosp.

15. FILED 9/6, 1928 M. M. Crowe
Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-2 1928

17. I HEREBY CERTIFY, That I attended deceased from 9-1, 1928, to 9-2, 1928 that I last saw her alive on 9-2, 1928 and that death occurred, on the date stated above, at 9:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity

1610

(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) P. E. Williams, M. D

9-3, 1928 (Address) Supt 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	DATE OF BURIAL
Highland	9/7 1928
20. UNDERTAKER	**ADDRESS**
[illegible]	1916 East 15

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.