

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson
Township Yreaw
City Kansas City (No. Kansas City Genl Hosp St. _____ Ward)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____

2. FULL NAME Walton, Frank

(a) Residence. No. Belmore Hotel St. Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22 - 1894

7. AGE YEARS 55 MONTHS 7 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Night Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lawrence
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Reverend Clerk
(Address) K.C. Genl Hosp.

15. FILED 3/29, 1929 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-29 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-15 1929 to 3-19 1929 that I last saw him alive on 3-29 1929 and that death occurred, on the date stated above, at 5:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Subac Pneumonia

100 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 101A (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

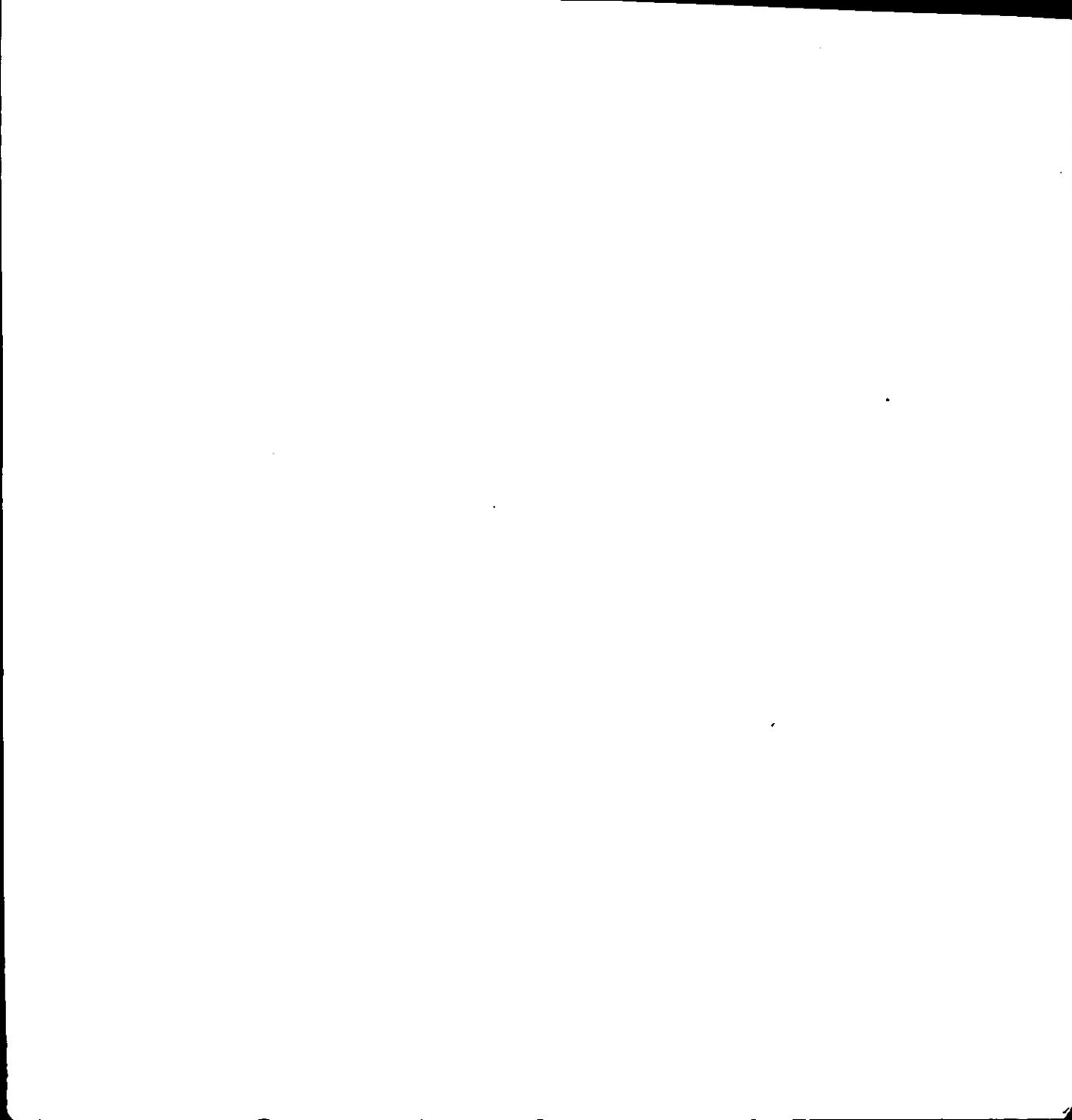
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Cult findings
(Signed) P. E. Williams, M. D.

3-29, 1929 (Address) Sub 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 Lawrence Kansas DATE OF BURIAL 3-30 1929

20. UNDERTAKER M. L. Foster ADDRESS K.C. Mo



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township H. City Primary Registration District No. 1002 Registered No. 13-3-3
 City H. City (No.) 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) Div.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 - 1873

7. AGE YEARS MONTHS DYS If LESS than 1 day, hrs. or min.
55 7 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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 3/29, 19 29 M. M. Crowe REGISTRAR
Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/29 19 29

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

CERTIFICATE WILL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

SUPPLEMENTARY

S-11042