S. No. 300
V. 10.48

FILED AUG 18 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26763

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3301

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1515 E. 12th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 3168
d. STREET ADDRESS (If rural, give location): 1515 E. 12th St.

3. NAME OF DECEASED (Type or Print): a. (First) Frank b. (Middle) — c. (Last) Alexander
4. DATE OF DEATH (Month) (Day) (Year): July 5 1951
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 63 yrs. — If under 1 year: Months, Days; If under 1 hr.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Unknown 9
12. CITIZEN OF WHAT COUNTRY? Unknown
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Coroner's Office

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Per relatives to sign Autopsy
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Thos. A. Jones (Degree or title) Thos. A. Jones M.D.
23b. ADDRESS 1612 E 12th St
23c. DATE SIGNED 7/27/51

24a. BURIAL-CREMATION-REMOVAL (Specify): Burial
24b. DATE 8-3-51
24c. NAME OF CEMETERY OR CREMATORY: K. C. College of Osteopathy
24d. LOCATION (City, town, or county) (State): Kansas City, Mo.

DATE REC'D BY LOCAL REG. 8-2-51
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. L. Davis K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed C.E. 4417

Signed.....
Student Embalmer

Licensed Embalmer No. 4417

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.