Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Jackson

Township

or

Village

or

City Kansas City (NO. 1882 Terrace St.; Ward)

ordusor 17 Summit

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

Registration District No. 399 File No. 28228

Primary Registration District No. 1002 Registered No. 2661

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Janette Billamiba

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: Mex

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Aug (Month) 4 (Day), 1908 (Year)

AGE: 3 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): Child

BIRTHPLACE (City or town, State or foreign country): Mex

PARENTS

NAME OF FATHER: Pantaleon Billamiba

BIRTHPLACE OF FATHER (City or town, State or foreign country): Mex

MAIDEN NAME OF MOTHER: Manea Gandes

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mex

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pantaleon Billamiba

(ADDRESS) 1882 Terrace

Filed AUG 6 191 W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August 4th (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 3, 1911, to Aug 4, 1911, that I last saw her alive on Aug 4, 1911, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

9 Whooping Cough

109 P

(Duration) yrs. mos. 14 ds.

Contributory (SECONDARY) Pneumonia

(Duration) yrs. mos. 60 ds.

(Signed) E. Anderson M. D.

Aug 6, 1911 (Address) 1706 Summit St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Oak Grove

DATE OF BURIAL: Aug 6, 1911

UNDERTAKER: Maurice M Quesk

ADDRESS: 3015 Main St

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *I*_____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS