

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

24488

1264

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1264
 Township Linn Primary Registration District No. 1002 Registered No. _____
 City Kansas City (No. Trace Hospital) St. _____ Ward _____

2. FULL NAME

Flora I. Master
 (a) Residence. No. 1615 Poplar 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. 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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. H. Master
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 42 4 11
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Kansas
 10. NAME OF FATHER Jesse Jones
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill
 12. MAIDEN NAME OF MOTHER Elizabeth Hubble
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT W. H. Master
 (Address) 1615 Poplar
 15. FILED 7/5 19 20 M. M. Crone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3 19 20
 17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1920, to July 3, 1920, that I last saw him alive on July 3, 1920, and that death occurred, on the date stated above, at 9:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Embolism
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) Loprotomy { Patric occlusion
one Jul 26 20. { Tuberculosis
 (duration) _____ yrs. _____ mos. _____ da.

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 BY PHYSICIAN? _____
 (Signed) J. S. Sheldon M. D.
 (Address) Roth Bldg
 *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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Forest Hill July 6 19 20
 20. UNDERTAKER ADDRESS
W. W. Newcomer's Sons Inc.

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.

WHILE BEING WITH OUTWARD INK—THIS IS A PERMANENT RECORD

