

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

Do not use this space

11776

1. PLACE OF DEATH

Comp. Jackson Registration District No. _____
Township Kearney Primary Registration District No. _____
Kansas City, 2121 Forest.

File No. _____
Registered No. 1705
St. _____ Ward _____

2. FULL NAME

Sallie Grayshaw
(a) Residence. No. 2121 Forest 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 Female 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26, 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
44 8 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(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) Louisiana

PARENTS

10. NAME OF FATHER Henry Stewart

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) don't know

12. MAIDEN NAME OF MOTHER Martha Cook

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) don't know

14.

INFORMANT Blairnce Marcus
(Address) 2110 Forest St.

15.

FILED 4/16, 25 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 1925

17. I HEREBY CERTIFY, That I attended deceased from Apr 8, 1925 to Apr 11, 1925 that I last saw alive on Apr 11, 1925 and that death occurred, on the date stated above, at 3:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sales Pneumonia
101A
(duration) _____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) Unknown
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? smear

(Signed) D.M. Miller M. D.

4-15, 1925 (Address) 1504-E-18-76th

*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

Highland Cem. DATE OF BURIAL 4/16 1925
20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lyden

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

