WRITE P[illegible]ADING INK--THIS IS [illegible]MANENT RECORD

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.

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

Do not use this space.

1095

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 1095

Township: Kaw — Primary Registration District No.: 1002 — Registered No.: 142

City: Kansas City (No. St. Luke's Hospital St. Ward)

2. FULL NAME Vivian Dry

(a) Residence. No. 4036 Warwick Blvd. 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: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Paul H. Dry

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 30, 1895

7. AGE: Years 31 — Months 2 — Days 9 — If LESS than 1 day, hrs. or min.

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): Kansas

PARENTS

10. NAME OF FATHER: John W. Wharton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Indiana
12. MAIDEN NAME OF MOTHER: Eliza Ladd
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Indiana

14. INFORMANT: Paul H Dry (Address) 4036 Warwick Blvd

15. FILED: Jan 11, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR): January 9 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1926, to Jan 9 1927, that I last saw her alive on Jan 9, 1927, and that death occurred, on the date stated above, at 1:50 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sepsis following Eclampsia — (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Pneumonia — Coversion — Sinus Thrombosis (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) Buford T. Hamilton, M. D

1/4, 1929 (Address) 602 Argyle.

*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~~: Mt. Moriah Cem — DATE OF BURIAL: 1-11-1927

20. UNDERTAKER: Stine & McClure — ADDRESS: 924 Oak

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township — Primary Registration District No. 1002 — Registered No. 142
City Kansas City, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Vivian Dry
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
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 1/11, 1927 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 9, 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 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:
Sepsis following Eclampsia, Lobar Pneumonia
Puerperal (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Cavernous sinus Thrombosis, (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFA... INK... PERM... ENT RECORD

N. B.—Every item of information ... AGE should ... TLY. PHYSICIANS should st... CAUSE OF DEATH in plain terms, ... properly classified. Exact st... OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-1095