

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

Do not use this space.

1363

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Jay Primary Registration District No. 609

City Jay City Mo (No. 609) Stephens (Ward)

File No. 410

Registered No. 410

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 609 Stephens 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 Fe

4. COLOR OR RACE Cul

5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min. 87

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____

(STATE OR COUNTRY) Ky

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Ky

12. MAIDEN NAME OF MOTHER Elnice

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Ky

14.

INFORMANT Scott Smith

(Address) 4135 1/2 miles E of Blvd

15.

FILED Jan 28 1927 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1927

17. _____

I HEREBY CERTIFY, That I attended deceased from Jan 27 1927 to Jan 27 1927 that I last saw her alive on Jan 27 1927 and that death occurred, on the date stated above, at 3:50 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

92A over (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acute Myocarditis

over (duration) 28 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? clinical

(Signed) D. W. Davis M.D.

Jan 28 1927 (Address) 7308 Washington St.

*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 _____ DATE OF BURIAL _____

Maple Hill Jan 29 1927

20. UNDERTAKER Hartley Bros ADDRESS 279 Lydia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT 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.

Fair