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

Do not use this space.

4909

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1002

City K.C. Mo. (No. 2415 Olive St. St. Ward)

File No.

Registered No. 707

2. FULL NAME Mary Ann Jones

(a) Residence. No. 2415 Olive 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: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-10-1861

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
65	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(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) Missouri

PARENTS

10. NAME OF FATHER James Patter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Ephraim Jones
(Address) 2415 Olive St.

15. FILED 2/18, 1927 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-17 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-16-27, 19__, to 2-17-27, 19__, that I last saw her alive on 2-17-27, 19__, and that death occurred, on the date stated above, at 12:30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93C

106B

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Bronchitis

(duration) 10 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) Leslie B. Miller, M. D.

2/18, 1927 (Address) 1201 Realty K.C. Mo

*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: Elmwood

DATE OF BURIAL: Feb. 1927

20. UNDERTAKER: Mrs. C. L. Forster

ADDRESS: K.C. Mo.

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.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD

1201 Rialto