

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 8182
 Township Kearney Primary Registration District No. 1002 Registered No. 1035
 City K.C. Mo. (No. 314 Clinton Place) St. _____ Ward _____

2. FULL NAME

Mary Wilson
 (a) Residence. No. 314 Clinton Pl. 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 Chas. Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April-4-18

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
86 | 11 | 5 | _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (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) Ohio

10. NAME OF FATHER Wm Spake

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Anna W. Creepbaum
 (Address) 406 No. 16th, K.C. Mo.

15. FILED 3/10 1927 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 3-6 1927, to 3-9 1927
 that I last saw him alive on 3-9-27 P.M. 1927, and that death occurred, on the date stated above, at 3:20 P.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Edema of lung.
10713
111 B / 100 B
 (duration) yrs. mos. ds. 4

CONTRIBUTORY (SECONDARY) Cerebral aneurysm
 (duration) yrs. mos. ds. 4

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: At Residence

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? NO
 WHAT TEST CONFIRMED DIAGNOSIS? Pharmacologic
 (Signed) W. B. Elliott, M. D.
3/10, 1927 (Address) 622 So. 10th

*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 St. Hope DATE OF BURIAL Mar 11, 1927

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

PARENTS

6220 Alms

**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 H. City Primary Registration District No. 1002 Registered No. 1035
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mary Wilson
 (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) W

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)

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) Unknown

14. INFORMANT _____ (Address)

15. FILED 3/10, 1927 M. M. Crowe REGISTRAR
Asch

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from _____ 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:

CONTRIBUTORY (SECONDARY) _____ (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 _____

20. UNDERTAKER _____ ADDRESS _____

REGIS'ARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY