

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

Do not use this space.

11868

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. 837 West 62nd St.)

Registration District No. 399
Primary Registration District No. 399 1902

File No. 1664
Registered No. 1664
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 837 West 62nd St. St. _____ Ward _____
(Usual place of abode)

Jamerson, Mo.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. — ds. How long in — yrs. — mos. — ds. if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10, 1878

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
49 2 11

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER George D. Grant

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

12. MAIDEN NAME OF MOTHER Mary Bryan

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

14. INFORMANT Geo E Grant (Address) Jefferson City, Mo.

15. FILED 421-27 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 21 1927

17. I HEREBY CERTIFY, That I attended deceased from 4/20/27 to 4/21/27, 1927, and that I last saw her alive on 4/21/27, 1927, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
9347 7421
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Arterial hypertension
(duration) Some 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? Chemical
(Signed) John Neal, M. D.

4/21, 1927 (Address) 1734 Argyr in Bldg

*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 Sallatin Mo. DATE OF BURIAL 4/27/27

20. UNDERTAKER The Freeman mortuary ADDRESS 3146 Main St.

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—VITAL STATISTICS—DEPARTMENT OF HEALTH

