

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

Do not use this space.

11974

1. PLACE OF DEATH
 County..... **Jackson** Registration District No. **608**
 Township..... **Kay** Primary Registration District No. **B993**
 City..... **Kansas City** (No. **4336 Brooklyn**) St. **Ward**

File No.
 Registered No. **11770**

2. FULL NAME **Mrs Emma W. Sutherlin**
 (a) Residence. No. **4336 Brooklyn** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 14 - 1871**

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. min.
56 | 3 | 13

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **House wife**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Shawnee**
 (STATE OR COUNTRY) **Kans.**

10. NAME OF FATHER **Joseph Chase**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Rhode Island**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Amanda Chen**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **do not know**
 (STATE OR COUNTRY)

14. INFORMANT **Mrs Frank Marker**
 (Address) **5723 Montgald**

15. FILED **4/29 27** **M. M. Crowe**
 REGISTRAR **Over**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 27 19 27**

17. I HEREBY CERTIFY, That I attended deceased from **Apr 10** 19**27** to **Apr 27** 19**27**, that I last saw h.e. alive on **Apr 27** 19**27**, and that death occurred, on the date stated above, at **4:30** P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tubercular Tuberculosis

31 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
 WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **positive findings**
 (Signed) **H. H. ...**, M. D.
Apr 27 19 27 (Address) **Wood Haven at h**

*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 **Mount Hope R.C.** DATE OF BURIAL **4/29/27**

20. UNDERTAKER **The Freeman Mortuary** ADDRESS **3146 Main**

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.

