

JUN 27 1927

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

Do not use this space.

14926

1. PLACE OF DEATH

County Jackson  
Township Polk  
City Independence (No. ....)

Registration District No. 398  
Primary Registration District No. 3019

File No. ....  
Registered No. 144  
St. .... Ward

2. FULL NAME

(a) Residence. No. 201 So. Pendleton Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 20 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 31 - 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
77 1 12

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) at Home  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) New Toronto Canada

10. NAME OF FATHER Dixon Carson

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) Dublin Ireland

12. MAIDEN NAME OF MOTHER Mary G. Carson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) Dublin Ireland

14. INFORMANT Mollie Showers  
(Address) 106 North River Blvd.

15. FILED May 13, 27 H. L. Cook REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to May 13, 1927 that I last saw her alive on May 13, 1927, and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Organic Heart Trouble  
& gastric ulcers of stomach  
70%  
10% (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H. M. Baird, M. D.

5/14 1927 (Address) Independence 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 Mound Grove DATE OF BURIAL 5-15 1927

20. UNDERTAKER C. L. Carson ADDRESS Independence 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.

RECORD



**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. 398 File No. ....  
 Town Independence Primary Registration District No. 3019 Registered No. 144  
 City ..... St. .... Ward)

**2. FULL NAME**

(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 D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Std.

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)

**14.**

INFORMANT .....  
 (Address)

**15.**

FILED 7/19/27 F L Cook REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
 that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Essential heart trouble + gastric ulcers of stomach + aortic Regurgitation.

CONTRIBUTORY (SECONDARY) .....

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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