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

Do not use this space.

18269

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas (No. St. Marys Hospital St. Ward)
Registration District No.: 399
Primary Registration District No.: 1002
File No.:
Registered No.: 22767

2. FULL NAME: Catherine Flores
(a) Residence. No. 2310 Mercier St., 3 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred X yrs. X mos. X ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: None

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 9-1918

7. AGE: Years 9 | Months X | Days X | If LESS than 1 day, ____ hrs. or ____ min.

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): None
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Parsons Kansas

PARENTS
10. NAME OF FATHER: Miguel Flores
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mexico
12. MAIDEN NAME OF MOTHER: Lorenzo Flores
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mexico

14. INFORMANT: Miguel Flores
(Address): 2310 Mercier

15. FILED: June 10, 1927 M. M. Crowe Registrar
Asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1927 to June 9, 1927 that I last saw h. alive on 6-9-27, and that death occurred, on the date stated above, at 6 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculous Meningitis
T.B.P.A.
(duration) yrs. mos. 17 ds.

CONTRIBUTORY (SECONDARY): None
(duration) yrs. mos. ds.

32 A

18. WHERE DID 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? None

(Signed) H. L. Drury, M. D.
6/10, 1927 (Address) 214 Medical Arts 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: St Marys Cem
DATE OF BURIAL: June 11 1927

20. UNDERTAKER: Kettelkamp Fun. Home
ADDRESS: City

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] Off [illegible] 130-3[illegible] [illegible]

[illegible]

H. P. [illegible]