

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

Do not use this space.

18400

1. PLACE OF DEATH

County Jackson
Township Keau
City Kansas

Registration District No. 399
Primary Registration District No. 1002
(No. Old City Hospital)

File No. _____
Registered No. 2503
St. _____ Ward _____

2. FULL NAME

Georgia Brown Talbot

(a) Residence. No. 2306 Grove St. 9 Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 9 mos. — ds. _____
(If nonresident give city or town and State) How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

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

July 20-1878

AGE <u>48</u> YEARS	MONTHS <u>10</u>	DAYS <u>28</u>	IF LESS than 1 day, <u>hrs.</u> or <u>mins.</u>
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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

Housework

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

PARENTS

10. NAME OF FATHER

John Brown

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

Missouri

12. MAIDEN NAME OF MOTHER

Francis Plummer

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

Missouri

14.

INFORMANT

(Address)

Edward Brown
2440 Michigan

15.

FILED

6/20 27 M. M. Crouse
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

6-18 1927

17.

I HEREBY CERTIFY That I attended deceased from 6-13, 1927, to 6-18, 1927 that I last saw her alive on 6-18, 1927, and that death occurred, on the date stated above, at 10:30 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Hypostatic Lobar Pneumonia
10/10
8/10 10/10
Cerebral Apoplexy
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Microscopical
(Signed) H. W. Smith, M. D.

6-18, 1927 (Address) Old City Hospital

*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

West Lawn June 21 1927

20. UNDERTAKER

ADDRESS

THATCHER'S FUNERAL HOME 15207-5th

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.

