

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

Do not use this space.

File No. *240390*

1. PLACE OF DEATH

County *Jackson*  
Township *Kan*  
City *Kansas city, mo*

Registration District No. *C.A.M. Kanke*  
Primary Registration District No. *1513 Lydia*

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Georgia Adams*

(a) Residence. No. *1513 Lydia ave* St. \_\_\_\_\_  
(Usual place of abode)

Ward *2*  
(If nonresident give city or town and State)  
Length of residence in city or town where death occurred *39* yrs. mos. \_\_\_\_\_  
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 *W.H. Adams*

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*55*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housekeeper*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER *Wm Lacey*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *W.H. Adams*  
(Address) *1513 Lydia ave*

15. FILED *7-9-27* *M.M. Crowe* REGISTRAR  
*asst*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 6 1927*

17. I HEREBY CERTIFY, That I attended deceased from *June 17*, 1927, to *July 6*, 1927, that I last saw her alive on *July 6*, 1927, and that death occurred, on the date stated above, at *1: A. M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*9:30*  
*9:23*  
*36 Cerebral Apoplexy*  
(duration) yrs. mos. da. *2*  
CONTRIBUTORY *Septicemia (1 month)*  
(SECONDARY) *Renal insufficiency (possibly Syphilis)*  
(duration) yrs. mos. da. *3*

18. WHEN WAS DISEASE CONTRACTED *38*  
IF NOT AT PLACE OF DEATH. \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? *yes*  
WHAT TEST CONFIRMED DIAGNOSIS? *Call Murray Kane, M.D.*  
(Signed) \_\_\_\_\_

*7/7*, 19 *27* (Address) *1217 Pased*  
\*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 *Westlawn* DATE OF BURIAL *7/8 1927*

20. UNDERTAKER *John J. Greenstreet* ADDRESS *1819 E. 15th St. K.C. 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.

