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

Do not use this space.

24289

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. 3076

Township Kaw — Primary Registration District No. ..... — Registered No. .....

City Kansas City (No. K.C. Gen'l Hosp. ..... St. ..... Ward)

2. FULL NAME Davis, Betty Lou

(a) Residence. No. 1416 Holmes St., 2 Ward. (Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ..... ds. How long in U.S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 12 1926

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1	9	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Joseph (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Carl Davis

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

12. MAIDEN NAME OF MOTHER Ida Butts

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

14. INFORMANT Record Clerk (Address) K.C. Gen'l Hosp.

15. FILED 8/6, 1927 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-5 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-31, 1927 to 8-5, 1927 that I last saw her alive on 8-5, 1927 and that death occurred, on the date stated above, at 4:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Infectious Diarrhoea

119E

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 113B

(duration) ..... yrs. ..... mos. ..... ds.

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) George C. Lee, M. D

8-5, 1927 (Address) Asst Supt K.C. Gen. Hosp

*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
Stanberry Mo.	8-7 1927
20. UNDERTAKER	ADDRESS
O V Mast	1415 East 15

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.