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

Do not use this space.

24352

File No. .....
Registered No. 3130

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. 3239 E 6th St. 9 Ward)
Registration District No. 399
Primary Registration District No. 1002

2. FULL NAME Belle Hughes
(a) Residence. No. 3239 E 6 St., 10 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: Fe
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1870 - Aug 1 -

7. AGE: Years 57 | Months 0 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Mo.

PARENTS
10. NAME OF FATHER W. L. Marshall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) No Record

14. INFORMANT Moses Hughes
(Address) 3239 E - 6th

15. FILED 8/12, 1927 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug - 12 1927

17. I HEREBY CERTIFY, That I attended deceased from 8/1 -, 1927 to 8/12 -, 1927 that I last saw h. a. alive on 8/11 -, 1927 and that death occurred, on the date stated above, at 3:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Inflammatory Nephritis
1 / 29 d
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Pneumonia
(duration) ..... yrs. ..... mos. 10 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) D. R. Russell, M. D
8/12, 1927 (Address) 3011 - Indep. Ave.

*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: Boonville Mo
DATE OF BURIAL: Aug-14 1927
20. UNDERTAKER: Mrs. C. L. Forster
ADDRESS: Kansas 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.

Indp & Bentan

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