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

Do not use this space.

24415

1. PLACE OF DEATH

County Jackson — Registration District No. 309 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 3202

City Kansas City (No. K.C. General Hosp. St. Ward)

2. FULL NAME Stevens, Mary

(a) Residence. No. 1504 Norton St., 12 Ward (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 12 1888

7. AGE: Years 38 — Months 4 — Days 3 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Restaurant
(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: John Geer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Sarah Boyle
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

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

15. FILED 8/16, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug. 15 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-22, 1927 to 8-15, 1927 that I last saw her alive on 8-15, 1927, and that death occurred, on the date stated above, at 10:45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General septicemia resulting from cellulitis of face
15 B
15 B
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Furuncle of lip
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 15 B

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) George C. Lee, M. D.
8-16, 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: New Hampton Mo — DATE OF BURIAL: Aug 17 1927

20. UNDERTAKER: Rose & Co — ADDRESS: 15 Jackson

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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Jackson — Registration District No. 399 — File No.
Township: City — Primary Registration District No. 1002 — Registered No. 32 82
City: Kansas City (No. ..., St. ..., Ward)

2. FULL NAME Mary Stevens

(a) Residence. No. ..., St., ..., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 12-1889

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	4	3	

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY)

14. INFORMANT ...
(Address)

15. FILED 9/16, 19 27 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY) ...
... (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) ..., M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Ev... CAUSE OF ... REGISTRARS SHALL NOT RECEIVE ... OR C... ES UNTIL THEY A... PRESCRIBEL... W...

S-24015