

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

Do not use this space.

24439

1. PLACE OF DEATH

County Jackson

Registration District No. 1002

Township Jackson

Primary Registration District No. 1002

City K.C.Mo. (No. 1920-E-28th St.)

File No. _____

Registered No. 3227

St. 27th Ward

2. FULL NAME

(a) Residence. No. 1920-E-28th St.,
(Usual place of abode)

Ward. _____
(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

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)

Wid

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

J. Gale

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

June 9 - 1858

7. AGE

YEARS 79

MONTHS 3

DAYS 9

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Housework

(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)

Virginia

10. NAME OF FATHER

Thornton W. Templeman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Virginia

12. MAIDEN NAME OF MOTHER

Harriett Catter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Virginia

14.

INFORMANT Elizabeth H. Graham
(Address) 1920-E-28th St

15.

FILED 8/19/27 M. H. Craive
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug - 18, 1927

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Aug 16, 1927

that I last saw her alive on Aug 15, 1927, and that death occurred, on the date stated above, at 4 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis
75 B
10 1/2 (duration) yrs. 9 mos. - da.

CONTRIBUTORY (SECONDARY)

Senility
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Glenn H. Broyles, M. D.
8/18/27 (Address) 3123 + Prospect K.C.Mo.

*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

Bethany Missouri Aug 20, 1927

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster 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.

PERMANENT RECORD

3.8.11 100%

100%

100%

100%

100%

100%

100%