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

Do not use this space.
24588

1. PLACE OF DEATH
County: Jackson
Township: Raw
City: K.C. Mo. (No. 3953 Hyde Park St. Ward)
Registration District No.
Primary Registration District No.
File No.
Registered No.

2. FULL NAME: Eva Strong
(a) Residence. No. 3953 Hyde Park 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: Fe
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: Clara Strong

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2/27/1840

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 87 | 6 | 4 | |

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): Sweden

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

14. INFORMANT: Mrs. August Carlson
(Address) 3953 Hyde Park

15. FILED 9-3, 1927 M M Crowe
Asst. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug-31 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to Aug 30 1927 that I last saw her alive on Aug 30 1927, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93C
97
(duration) ? yrs. mos. ds.
CONTRIBUTORY (SECONDARY): Arterio Sclerosis
(duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) C. L. Martin, M.D.
9/1, 1927 (Address) 310 Chambers Bld

*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: Forest Hill
DATE OF BURIAL: Sept ~~Aug~~ 3-1927

20. UNDERTAKER: Mrs. C. L. Forster
ADDRESS: 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.