

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

Do not use this space.

30475

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City No. 3300 Broadway

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 2  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mary A. Gimber

(a) Residence No. 4147 State Line St. 7 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. da. 7 How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX J 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 20, 1845

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>81</u>	<u>11</u>	<u>1</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
(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) New York

10. NAME OF FATHER Elizabeth Clark

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Margaret Grindman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) New York

14. INFORMANT Mrs. Clark Smith (Address) 3300 Broadway

15. FILED 10-22-1927 M M Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Oct 21, 1927 that I last saw h. A. G. alive on Oct 20, 1927, and that death occurred, on the date stated above, at 1392 m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

11th Branch - Pneumonia  
1927  
110 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 da.  
CONTRIBUTORY Influenza (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**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 Spiral

10/22 (Signed) Tom Jones, M. D. (Address) Rousey St. 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 Forest Hill DATE OF BURIAL 10-22-1927

20. UNDERTAKER S. H. Newcome's Sons ADDRESS St. C. Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

M. 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.

602 Argyle St  
Victor 6848.