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

Do not use this space.

33584

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 4355

Township: Flaw — Primary Registration District No.: 1002 — Registered No.:

City: Kansas City (No. St. Josephs Hosp. St. ..... Ward)

2. FULL NAME Mrs. Georgia Radford

(a) Residence. No. 904 Penn. St., 1 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: F
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 3 - 1889

7. AGE: YEARS 68 — MONTHS 10 — DAYS 11 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Beauty Operator 54B 189
(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): St. Joseph Mo.

PARENTS
10. NAME OF FATHER: George Dean
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): North Carolina
12. MAIDEN NAME OF MOTHER: Elizabeth Martin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): North Carolina

14. INFORMANT: R. H. Martin (Address) 904 Penn St.

15. FILED 11/16, 1927 M. M. Crowe ass. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 14 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1927, to Nov. 14, 1927, that I last saw her alive on Nov 14, 1927, and that death occurred, on the date stated above, at 11:35 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Streptococcus
Peritonitis
following Operation
Fibroid Tumors (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY): [signature] (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF Nov. 9, 1927
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [signature], M.D.
Nov. 16 1927 (Address) 844 Tatty

*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: St. Joseph Mo. — DATE OF BURIAL: Nov 17 1927

20. UNDERTAKER: D. H. Newcomer's Sons — 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.

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

10th & Grand. 844 Lathrop Bldg.
Victor 7010.
1-5:30