

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

Do not use this space.

33621

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Kans Primary Registration District No. _____
 City Kansas City No. 915 Vine Registered No. 1091
 St. _____ Ward _____

2. FULL NAME Phillie Ann Jones
 (a) Residence No. 915 Vine 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 W 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) unk 1865

7. AGE YEARS MONTHS DAYS H LESS than 1 day, _____ hrs. or _____ min.
About 64

8. OCCUPATION OF DECEASED House wife
 (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) mo

10. NAME OF FATHER Mr. Gibson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) va

12. MAIDEN NAME OF MOTHER Leah Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs. Mary Boyd
 (Address) 915 Vine St.

15. FILED 11-19-27 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from November 4, 1927, to November 16, 1927
 that I last saw him alive on Nov. 16, 1927, and that death occurred, on the date stated above, at 7:35 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial nephritis
 131 (duration) 3.3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Focal Infection
 (duration) 6.7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Unknown
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? no
 (Signed) J. J. Faugh, M. D.
11/16, 19 27 (Address) 915 Vine St.

*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 Highland Cemetery DATE OF BURIAL 11-19-27

20. UNDERTAKER St. Andrew ADDRESS 1606 E. 18th

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

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.

