

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

Do not use this space.

5082

1. PLACE OF DEATH

County Jackson
Township Clark
City Kansas City Mo. (No. 1025 Jefferson)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 744
St. _____ Ward _____

2. FULL NAME

Mrs. Ora May Meade

(a) Residence. No. 1025 Jefferson St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-25-1884

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____hra. or _____min.
44 00 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cooper County Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Pete Clawson

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

12. MAIDEN NAME OF MOTHER Ruth Gramer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Mrs. Geo. a. Meade
(Address) 1025 Jefferson

15. FILE 2-18-25 M. M. Crowe REGISTRAR
East

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 18 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1926 to Feb 17, 1928 that I last saw h. or alive on Feb 17, 1928, and that death occurred, on the date stated above, at 5-40-A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

460 Cancer Lower Intestines

CONTRIBUTORY (SECONDARY) 45 (duration) _____ yrs. 6 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? yes

WHAT TEST CONFIRMED DIAGNOSIS. Chemical

(Signed) C. M. Carroll, M. D.

(Address) 1330 Summit

*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 La Mine Mo DATE OF BURIAL Feb 19 1928

20. UNDERTAKER A. P. Doehler ADDRESS 1415 E 15

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.

