

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

Do not use this space.

1. PLACE OF DEATH

County *Pickson*

Registration District No. *399*

Township *Law*

Primary Registration District No. *1007*

City *Kansas City*

State *Kennessee*

File No. *5168*
Registered No. *830*
St. _____ Ward _____

2. FULL NAME

Mary Board

(a) Residence No. *2830 Kennessee* St. _____ Ward _____

(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

MEDICAL CERTIFICATE OF DEATH

3

3. SEX

Fe

4. COLOR OR RACE

col

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) *Unknown 874*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

53

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

(Address)

Mollie Powell 2830 Kennessee

15. FILED

19. *28*

M.M. Green

REGISTRAR

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

7/23 1928

17.

I HEREBY CERTIFY That I attended deceased from *2/21*, 19*28*, to *2/23*, 19*28*, that I last saw her alive on *2/22*, 19*28*, and that death occurred, on the date stated above, at *12:10 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pertontic for ruptured spleen absent

CONTRIBUTORY

Large fibroid tumor

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

20. WAS THERE AN AUTOPSY? *no*

21. WHAT TEST CONFIRMED DIAGNOSIS *Clinical Finding*

(Signed) *J. Employment*, M. D.

7/24, 1928 (Address) *980 S. West Blvd Kansas*

*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

DATE OF BURIAL

Maple Hill

7/25 1928

20. UNDERTAKER

ADDRESS

Hatkins Bros 179 9 Lydia

M^a Cormack.

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 299 File No.
Towship..... Primary Registration District No. 10020 Registered No. 830
City N.C. (No.) St. Ward

2. FULL NAME Mary Board

(a) Residence. No. 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 F 4. COLOR OR RACE B. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W.
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 3/24/28 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-22 19 28

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him give on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following ruptured pelvic abscess abscess caused by breaking down of fibroid.

CONTRIBUTOR (SECONDARY) Large fibroid tumor not malignant

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

