

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

Do not use this space.

8984

1. PLACE OF DEATH

County Jackson
Township St. Clair
City Kansas City, Mo. (No. 1420 East 9)

Registration District No. 399
Primary Registration District No. 1002

File No. 1157
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1420 East 9 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-4-1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 1 11

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) None
(c) Name of employer _____

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

10. NAME OF FATHER James Skidmore

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

12. MAIDEN NAME OF MOTHER Agnes Long

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

14. INFORMANT Mrs Ollie Roberts
(Address) 1420 East 9

15. FILED 3/15, 1928 M. M. Crane REGISTRAR
Assn.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-15 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 5th, 1928, to Mar 14th, 1928, and that I last saw h. or alive on Mar 14th, 1928, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myo-Carditis
900 90B
97 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Atherosclerosis
(SECONDARY) (duration) 2 yrs. _____ mos. _____ ds.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Inspection
(Signed) James T. Davis, M. D.

3-15, 1928 (Address) 1659 Park Ave

*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 Memorial Park Cem DATE OF BURIAL Mar 17 1928

20. UNDERTAKER A. P. Dochler 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.

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

659 Park,
Be. 1978