

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

Do not use this space.

9253

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township New Primary Registration District No. 1002
 City Kansas City (No. 3028 Baltimore ave)
 St. _____ Ward _____

File No. _____
 Registered No. 14888
 St. _____ Ward _____

2. FULL NAME

Mrs. Cassandra Darst Scott
 (a) Residence. No. Beaumont apt 3028 Baltimore Ward 3
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr 13 - 1855

| | | | | |
|--------|-----------|----------|-----------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
| | <u>73</u> | <u>1</u> | <u>15</u> | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
 (b) General nature of industry, business, or establishment in which employed (or employer) mother
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) near Platte City Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Robert Elley

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

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
 (STATE OR COUNTRY)

14. INFORMANT R. L. Calvert
 (Address) Kenneth, Kans

15. FILED 3/29 28 M. M. Browne REGISTRAR
user

MEDICAL CERTIFICATE OF DEATH Wednesday

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28, 1928

17. I HEREBY CERTIFY That I attended deceased from Mar 15 1928, to Mar 28 1928, and that I last saw h.c. alive on Mar 28 1928, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

115 127A 125B
Hepatic abscess
 (duration) yrs. mos. 15 da.

CONTRIBUTORY (SECONDARY) Influenza
 (duration) yrs. mos. 7 da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) J. W. Fair M. D.
 (Address) 7308 Washington

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Platte City Mo. DATE OF BURIAL Mar. 30 1928

20. UNDERTAKER Elyas Funeral Home 1800 Linwood
 ADDRESS _____



MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION REQUESTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson Registration District No. 399 File No. _____
 Township _____ Primary Registration District No. 1002 Registered No. 14 33
 City K. City (No. _____) St. _____ Ward _____

2. FULL NAME

Miss Cassandra Doris Scott

(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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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 3/29, 28 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 28 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hepatic abscess
Septicemic Colangitis?

CONTRIBUTORY (SECONDARY) Influenza (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF BIRTH _____

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

S-9253