

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

Do not use this space.

9358

1. PLACE OF DEATH

County Jackson Registration District No. 404
 Township Washington Primary Registration District No. 33-5-8
 City Harrisonville (No. _____) St. _____ Ward _____

2. FULL NAME Virginia Mae Brill

(a) Residence No. _____ St. _____ Ward Harrisonville Mo
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27 - 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
4 8 hrs. 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) East Lynn Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Lee Brill

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

12. MAIDEN NAME OF MOTHER Rushie Dike

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

14. INFORMANT Best Vest
 (Address) Grandview Mo

15. FILED P. 2, 19 28 R. P. Pransford
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 3 1928

17. I HEREBY CERTIFY That I attended deceased from March 2 1928, to March 3 1928, that I last saw h.c.t. alive on March 2 1928, and that death occurred, on the date stated above, at 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Infloxaemia
Mother died of Eclampsia
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 67B
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Glyceroloh
 (Signed) M. T. Kelley, M. D.
 (Address) Harrisonville Mo

*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 Belton Mo DATE OF BURIAL 3/4 1928

20. UNDERTAKER Ed George ADDRESS Belton Mo



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Jackson Registration District No. 204 File No.
 Township Washington Primary Registration District No. 3-3-8 Registered No. 13
 City (No.) St. Ward)

2. FULL NAME Virginia Mae Brill
 (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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (*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.
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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) Marionville Harrison Mo

12. MAIDEN NAME OF MOTHER

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

PARENTS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 3 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

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

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. (See reverse side for additional space.)

SUPPLEMENTARY

14. INFORMANT (Address)

15. FILED 6-2-28 Dr. Brainerd REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE AS PRESCRIBED BY LA.

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