

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

Do not use this space.

17287

20984

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 2550
Township East Primary Registration District No. 1097 Registered No. 2550
City Kennett (No. Lakeside Hospital) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1331 Locust St. 2 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

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March - 15 1885

7. AGE - YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 2 5

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Geo Cude

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

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) No Record

14. INFORMANT Robert Miller (Address) 1331 Locust St

15. FILED 5/22 28 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 20 - 1928

17. I HEREBY CERTIFY, That I attended deceased from 5:15, 1928, to 6:15, 1928, that I last saw her alive on 5:15, 1928, and that death occurred, on the date stated above, at 19:27 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Adynamic Illness

CONTRIBUTORY (SECONDARY) Post operative Appendicitis fibroid tumor non malignant

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF May 18th

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. R. Hoall, M. D.

5/21, 1928 (Address) 626 Lathrop

*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 Forest Hill DATE OF BURIAL May 22 1928

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. Mo.

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

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.

626 Lathrop Bldg
1322. 4