

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.

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

Do not use this space.

17422

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Yean

Primary Registration District No. 1002

City Kansas City

(No. 700 General Hosp.)

File No. 17422

Registered No. 17422

St. Ward

2. FULL NAME

(a) Residence. No. 850 Olive St. 9 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

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)

Sept. 9 - 1902

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ____ hrs. or ____ min.

45

8

22

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)

Atoka

(STATE OR COUNTRY)

Kansas

10. NAME OF FATHER

Wm. P. Denby

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ohio

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Louise Harper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ohio

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Reverend Clerk

700 C. Gen'l Hosp.

15.

FILED

6/1, 28

M. M. Croome
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

5-31 1928

17.

I HEREBY CERTIFY, That I attended deceased from

5-20, 1928, to 5-31, 1928
that I last saw her alive on 5-31, 1928, and that death occurred, on the date stated above, at 12:30 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of uterus

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 Did AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. E. Williams, M. D.

1-1, 1928 (Address) Sept 700 C. Gen'l Hosp.

*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

6-2 1928

20. UNDERTAKER

ADDRESS

D. U. Mast

DATE OF BIRTH: 1914
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]

DATE OF DEATH: 1944
PLACE OF DEATH: [illegible]

[illegible]

[illegible]

PHYSICIANS should state
OCCUPATION is very important.

should be carefully supplied. AGE
so that it may be properly classified.

PLE : AS PRESCRIBED BY LAW

OT RECEIVE A FEE FOR CERTIFICATES UN

MISSOURI STATE BOARD OF HEALTH 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. 399 File No. _____
 Township Raw Primary Registration District No. 1002 Registered No. 2396
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME James, Ada May Ada May James
 (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 _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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 _____

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 _____

6/1, 28 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS: _____

To James the
surname or is it
May - James is
surname

, 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

19

S-17422-