

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

Do not use this space.

20718

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Yreaw Primary Registration District No. 1007
 City Kansas City (On Kansas City Gene Hosp) (If nonresident give city or town and State) Ward)

File No. 2197
 Registered No. 2197

2. FULL NAME

Cross, Lila Irene
 (a) Residence, No. 4024 E 70th St., 16 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 (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 26 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>	<u>18</u>	

8. OCCUPATION OF DECEASED

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

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

PARENTS	10. NAME OF FATHER <u>Walter Cross</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>ga</u>
	12. MAIDEN NAME OF MOTHER <u>Willa Noah</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>mo</u>

14. INFORMANT Reverend Clerk
 (Address) K.C. Gene Hosp.

15. FILED 6/15 28 M. M. Lemire REGISTRAR
Asen

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14 1928
 17.

I HEREBY CERTIFY, That I attended deceased from 6-14 1928, to 6-14 1928
 that I last saw her alive on 6-14 1928 and that death occurred, on the date stated above, at 2:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
(Primary)
10/7/28
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 1000
 (duration) yrs. mos. ds.

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) P. E. Williams, M. D.

6-15, 1928 (Address) 507 K.C. Gene 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 St. Maria's DATE OF BURIAL 6/15 1928

20. UNDERTAKER Freeman Mortuary ADDRESS

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

10

**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 Primary Registration District No. 1002 Registered No. 23-97
 City N. City (No.) St. Ward

2. FULL NAME Lila Irene Cross
 (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. 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 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.

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)

PARENTS
 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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 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:
 (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.

14. INFORMANT (Address)

15. FILED 6/15 28 M. M. Brown REGISTRAR

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

20. UNDERTAKER ADDRESS
K. L. Mo

SUPPLEMENTARY

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

