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

Do not use this space.

27394

File No. 3470

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No.

Township Law — Primary Registration District No.

City Kansas City (No. Old City Hospt St. Ward)

2. FULL NAME Gertrude Williams

(a) Residence. No. 504 Tracy St., Ob 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. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 19, 1879

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
49	5	27	

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) Clarkesburg Mo

PARENTS

10. NAME OF FATHER Ben Dusley

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

12. MAIDEN NAME OF MOTHER Mahaley, Unk

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

14. INFORMANT Patient (Address) Gertrude Williams

15. FILED 8-18 1928 M M Crowe Assl REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1928, to Aug 16, 1928, that I last saw her alive on Aug. 16, 1928, and that death occurred, on the date stated above, at 5:35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post-partum hemorrhage

1437

1443 (duration) yrs. mos. 6 hrs

CONTRIBUTORY (SECONDARY) Puerperal sepsis

(duration) yrs. mos. 3 ds.

146

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Macroscopic

(Signed) Howard M. Smith, M. D

8/17, 1928 (Address) Old City Hospital

*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 West Lawn

DATE OF BURIAL 8-20 1928

20. UNDERTAKER H. B. Moore

ADDRESS 1820 E 1

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.

THIS IS A PERMANENT RECORD