

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

Do not use this space.

33747

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Tow Primary Registration District No. 1009
City Kansas City (No. 3740 Bell)

File No. _____
Registered No. 4288
St. _____ Ward _____

2. FULL NAME

Mrs. Gladie Ellen Kinnear
(a) Residence No. 3740 Bell St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 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 John Kinnear
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4-1851
7. AGE YEARS 76 MONTHS 10 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) mother
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Henry Albire

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

12. MAIDEN NAME OF MOTHER Mary Ann Crowe

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

14. INFORMANT John Kinnear (Address) 3740 Bell St

15. FILED 10/22, 1928 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

✓ 16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 1928 Sunday
17. I HEREBY CERTIFY That I attended deceased from June 28, 1928, to Oct 20, 1928 that I last saw her alive on Oct 20, 1928 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
12 1/2 (duration) yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Chronic Intestinal Nephritis (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATIVE PROCEDURE PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? renal tract & description
(Signed) Dr. M. M. Smith, M. D.
10/21, 1928 (Address) 505 E. 14th Ave. Temple
*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 Oct 23 1928

20. UNDERTAKER Elyar Funeral Home ADDRESS 1800 Duwood

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

MAKING RESERVED FOR BINDING

V. S. NO. 2.

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.

Wa. 0247

4200 Chestnut