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Do not use this space.

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

1. PLACE OF DEATH
County Jackson Registration District No. 399 File No. 9
Township Kaw Primary Registration District No. 1002 Registered No. 2
City Kansas City (No. Kansas City Genl Hosp ....St. ....Ward)

2. FULL NAME Evans Elizabeth
(a) Residence. No. 917 W 17th St., 3 Ward. (If nonresident give city or town and State)
(Usual place of abode)
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): Widow
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-1-1869
7. AGE: Years 59 Months 11 Days If LESS than 1 day, ...hrs. or ......min.
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) Kentucky

PARENTS
10. NAME OF FATHER Pas O'Malley
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Mary O'Malley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland

14. INFORMANT Record Clerk
(Address) Kansas City Genl Hosp

15. Filed Jan 1, 1929 M. M. Crane REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-1- 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-31-, 1928, to 1-1-, 1929
that I last saw her alive on 1-1-, 1929, and that death occurred, on the date stated above, at 5:00 a.m.

THE CAUSE OF DEATH* was as follows:
Bronchopneumonia
(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) P. E. Willcoxly, M.D.
1-1-, 1929 (Address) Supt. K. C. Genl 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: Union Cemetery
DATE OF BURIAL: 1-3-1929

20. UNDERTAKER: Stine & McClure
ADDRESS: 3235 Gillham Plaza

THIS IS A PERMANENT RECORD. WRITE PLAINLY WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

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