

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

Do not use this space.

1513

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Law Primary Registration District No. 1002 Registered No. 102
 City Kansas City (No. St. Mary's Hospital) St. _____ Ward _____

2. FULL NAME

Mrs Emma Kilbourn
 (a) Residence. No. 2108 E. 41st St. 15 Ward. _____
 (Usual place of abode)

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 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 Elton F. Kilbourn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
37

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) Kansas Iowa

10. NAME OF FATHER J. F. Poe

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT (Address) E. F. Kilbourn 2108 E. 41st.

15. FILED Jan 9 19 29 **REGISTRAR** M. M. Conner

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 1926, to Jan 8 -, 1929
 that I last saw her alive on 1-8-29, and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis, Chronic
 (duration) 5 yrs.? mos. da.

CONTRIBUTORY (SECONDARY) Cholecystitis
 (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 910 B
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF 1-3-29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? yes
 (Signed) Sam E. Owens, M. D.

1/9, 1929 (Address) 1018 mad St. K.C. Mo

*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 Mt Moriah **DATE OF BURIAL** Jan 11 29

20. UNDERTAKER R. V. Lindsey & Sons **ADDRESS** City

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

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.

172-48
109

235
2
2
31

Dr. Crow
1018 Medical Center