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

Do not use this space.

1522

File No. 112

Registered No.

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 569 Harrison St. St. Ward)

2. FULL NAME Dephalia Smith
(a) Residence. No. 569 Harrison St. St., 1 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Colored	widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 15 - 1884

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	7	21	

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) Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Jack Steward
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Owens.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Mary Steward
(Address) 569 Harrison St.

15. FILED Jan 9, 29 M. M. Cooper
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 6 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929 to Jan 6, 1929 that I last saw her alive on Jan 6, 1929, and that death occurred, on the date stated above at 3:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Mitral Insufficiency
(duration) — yrs. 2 mos. — ds.
CONTRIBUTORY (SECONDARY) Focal Infection
(duration) — yrs. 3 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY? no —
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. E. Brincac, M. D
1/7, 1929 (Address) 807 Southwestern Ave.

*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	DATE OF BURIAL
Highland Cem	1-9-1928
20. UNDERTAKER H. B. Moore	ADDRESS 1820 E. 18th

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 A PERMANENT RECORD