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

Do not use this space.

1527

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Kaw — Primary Registration District No. 1002 — File No. [illegible]
City Kansas City (No. Kansas City Gen'l Hosp St. ..... Ward) — Registered No. 116

2. FULL NAME Jenkins Otis Bessie

(a) Residence. No. Marquette Hotel St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
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) May 1 1896

7. AGE — Years: 32 | Months: 8 | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(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) Missouri

PARENTS

10. NAME OF FATHER Robert Kirkpatrick
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know
12. MAIDEN NAME OF MOTHER Martha Nebitten
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

14. INFORMANT Rena Clark
(Address) Kansas City Gen'l Hosp

15. FILED 1-10 1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-8 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-7, 1929, to 1-8, 1929, that I last saw h[illegible] alive on 1-8, 1929, and that death occurred, on the date stated above, at 8:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral meningitis
(Unclassified)
19 hr (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? No. DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab. Findings

(Signed) P E Williams, M.D
1-9, 1929 (Address) S. 42nd & C. Gen'l 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: Maple Hill — DATE OF BURIAL: 1/11 19 29

20. UNDERTAKER: [illegible] — ADDRESS: 1616 East 15

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