

32. Xmas

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1831

1. PLACE OF DEATH

County

Township

(City)

(No.)

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

St.

Ward.

(If nonresident give city or town and State)

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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND or (or) WIFE OF

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, that I attended deceased from

19

to

19

that I last saw him alive on 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophic Cardiomyopathy of the Heart

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

19

(Address)

*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

20. UNDERTAKER

ADDRESS

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. 1711 Tracy)

Registration District No.
Primary Registration District No.

File No.
Registered No. 424
St. Ward)

2. FULL NAME

Nealie Edwards Mitchell

Residence. No. 1711 Tracy St. Ward.
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Brunswick
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Law

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

12. MAIDEN NAME OF MOTHER Unk.

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

14. INFORMANT Mr. Mitchell
(Address) 1711 Tracy

15. FILED 1/28 29 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/23 19 29

17. I HEREBY CERTIFY That I attended deceased from 1/23 to 1/23 that I last saw him alive on 1/23, and that death occurred, on the date stated above, at 1/23 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Hypertrophic Curvature of Spine

CONTRIBUTORY (SECONDARY) 1/23 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED IN AUTOPSY?
(Signed) L. H. Turner M. D.

1/23, 19 29 (Address) Deputy Coroner
*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Lawn DATE OF BURIAL 1/29 19 29

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

SUPPLEMENT

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, go thru REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFYING L THEY ARE COMPLETE AS PRESCRIBED BY LAW

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