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

Do not use this space.

6447

1. PLACE OF DEATH

County Jackson — Registration District No. 349 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No.

City K. C. Mo. (No. 2204 Kansas Ave. St. Ward)

2. FULL NAME Mary C. Woolley

(a) Residence. No. 2204 Kans Ave St., 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: Fe

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) Apr-5-1847

7. AGE: Years 81 — Months 10 — Days 0 — 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) Illinois

PARENTS

10. NAME OF FATHER Solomon Dixon

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

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Mrs. Fred A. Ray (Address) 4521 Genesee

15. FILED 7/6, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1929, to Feb 5th, 1929 that I last saw her alive on Feb 4th, 1929, and that death occurred, on the date stated above, at 8:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Myocarditis

131

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1299

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis

(Signed) R. F. Boone, M.D.

7/6, 1929 (Address) 4610 Troost 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: Forest Hill — DATE OF BURIAL: Feb. 7 1929

20. UNDERTAKER: Mrs. C. L. Forster — ADDRESS: K. C. Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

23

2

2

31

4678

6914

4610 [illegible]

[illegible]

2-4-