

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

Do not use this space.

6462

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Law Primary Registration District No. 100  
 City Kansas City (No. 1717, Virginia) St. 4 Ward 4  
 2. FULL NAME Ruth Mickey  
 (a) Residence No. 77 Virginia St. 4 Ward 4  
 (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.

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. 4 Ward 4

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 28, 1891  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 37 11 6  
 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) Kansas City (STATE OR COUNTRY) Kansas  
 10. NAME OF FATHER Henry Mickey  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss. (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER Jednette  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mass. (STATE OR COUNTRY) \_\_\_\_\_  
 14. INFORMANT Sarah Gibson, friend (Address) 1718 Virginia  
 15. FILED 2/7 19 29 M. M. Crowe REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4-1929  
 17. Deputy Coroner  
 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 \_\_\_\_\_ m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Tuberculosis of Intestines  
Red Pentoseum (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 18. WHERE WAS DISEASE CONTRACTED 35  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
 20. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? autopsy  
 (Signed) R. W. Turner M.D.  
 (Address) Deputy Coroner  
 \*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 Highland DATE OF BURIAL 2/7 19 29  
 20. UNDERTAKER Hatkins Bros. ADDRESS 1729 Lydia

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.

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