

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

Do not use this space.

6847

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township 1st Primary Registration District No. 2002
City Kansas City (No. Genl Hosp # 2)

File No. _____
Registered No. 1003
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Graves, Malinda St. 4 Ward. 2
(Usual place of abode) 1914 1/2 Vine (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1874
7. AGE YEARS 55 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

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) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Scott, Martin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Mrs
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mrk.

14. INFORMANT Graves, George
(Address) 1914 1/2 Vine St.

15. FILED 3/1 1929 M. M. Crowe REGISTRAR
user

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-18 1929
17. I HEREBY CERTIFY, That I attended deceased from 2-16 1929, to 2-18 1929, that I last saw her alive on 2-18 1929, and that death occurred, on the date stated above, at 8:05 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumococci meningitis
8910
79A (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Stetic media (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 910
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & laboratory
(Signed) H. S. Smith M. D.
7/18 1929 (Address) Old City Hospital

*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 Blue Ridge Lawn 7/1 1929
DATE OF BURIAL

20. UNDERTAKER Hathins Bros 1729 Lydia
ADDRESS

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

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1
2
31

