

10919 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6848

1. PLACE OF DEATH

County Jackson
Township Raw
City K.C. Mo.

Registration District No. 399
Primary Registration District No. 162
(No. 3237 East 27th, St. 11 Ward)

File No. _____
Registered No. 1001
St. _____ Ward

2. FULL NAME

Minna B. Hagarty

(a) Residence. No. 3237-E-27th St. 11 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 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) Nov-30-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 2 27

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) Penn

10. NAME OF FATHER Bennis Donaldson

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

12. MAIDEN NAME OF MOTHER no Record

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

14. INFORMANT Mr. N. S. Murphy
(Address) 3237 East 27th St

15. FILED 31, 1929 M. M. Crowe REGISTRAR
Asst

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1929

17. I HEREBY CERTIFY, That I attended deceased from FEB 11 1929, to 2-27 1929 that I last saw her alive on 2-7-1929, and that death occurred, on the date stated above, at 7:30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
9:30
162

CONTRIBUTORY (SECONDARY) Myocarditis, Chronic (duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Powers, M. D.
728 1929 (Address) 27th & Indiana

*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

Forster Vault 2-1- 1929

20. UNDERTAKER ADDRESS

Mrs. E. L. Forster K.C. Mo.

Lin 0919

**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 Registration District No. 399 File No.
 Township Raw Primary Registration District No. 1002 Registered No. 101K
 City X 6 mo (No. 3337) St. Mo Ward

2. FULL NAME

(a) Residence. No. 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
 5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (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 (duration) yrs. mos. ds.
 (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 728 24 19 27 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/27 19 27
 17. I HEREBY CERTIFY That I attended deceased from 19, 19, that I last saw h..... alive on, 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
 (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? DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 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 /
Arrow Rock, Mo 728 19 27
 20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

8489-5