

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

Do not use this space.

6851

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township K. E. 15th Primary Registration District No. 1002
 City K. E. Mo. (No. General Hospital #2) St. 10018 Ward

2. FULL NAME Emma Hunt
 (a) Residence. No. 2641 Nine St. 9 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 40 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 Col
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70?
 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) MO
 10. NAME OF FATHER Chas Brown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) MO
 12. MAIDEN NAME OF MOTHER Julia Lucas
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) MO

14. INFORMANT Jennie Moore
 (Address) 2641 Nine st
 15. FILED 3/1 29 M. M. Crover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/28 1929
 17. I HEREBY CERTIFY, That I attended deceased from 2/24 to 2/28 1929 and that I last saw her alive on 2/27/29, and that death occurred, on the date stated above, at 7:50 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis of Liver
12-7-18
16-1-19 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Insanition (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED 12-2-18
 IF NOT AT PLACE OF DEATH _____
 19. DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) H. M. Smith, M. D.
2/29 1929 (Address) Gen Hosp #2 K.E. Mo
 *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. A.S.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Highland Cem 3-4-1929
 20. UNDERTAKER ADDRESS
J. B. Moore 1820 E 18th

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 FAINTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

235

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