

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

Do not use this space.

10544

1. PLACE OF DEATH

County Jackson
Township Daw
City Kansas City (No. Kansas City Genl Hosp)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 1043 St. _____ Ward _____

2. FULL NAME

Jones Pearl
(a) Residence No. 3609 Prospect St., 13 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas E Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 28 1907

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>22</u>	<u>11</u>	<u>10</u>	

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) Mo.

PARENTS

10. NAME OF FATHER Ortha E Vance

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

12. MAIDEN NAME OF MOTHER Grace McEubien

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland

14. INFORMANT Reverend Clerk
(Address) Kansas City Genl Hosp

15. FILED 3/2 19 29 M. M. Corwin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1 19 29

17. I HEREBY CERTIFY, That I attended deceased from 2:20, 19 29 to 3-1, 19 29
that I last saw her alive on 3-1, 19 29, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus
59
(duration) _____ yrs. mos. ds.

CONTRIBUTORY Diabetic Coma
(SECONDARY)
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Altimeter Ind + Glucose
(Signed) J. E. Williams M. D.

3-1 19 29 (Address) Supt. K. C. Genl Hosp.

*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 Mar 4 1929

20. UNDERTAKER Rose & Henderson ADDRESS 15th Jackson

WRITE FULLY, WITH UNFADING INK--- THIS IS A PERMANENT RECORD. 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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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County
Towship W. City
City W. City (No.) St. Ward

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 1043
St. 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 28-1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
22 11 3

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) (duration) yrs. mos. ds.
(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 3/2 19 29 M. M. Browne REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1 19 29

17. I HEREBY CERTIFY That I attended deceased from 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
..... (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

20. UNDERTAKER ADDRESS

WRITE PERMANENT, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B. - Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS how? State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRATION FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-10544