

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

Do not use this space.

10706

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas, Mo. (No. General Hospital #2)

Registration District No. 399
Primary Registration District No. 2003

File No. 1214
Registered No. 1214
St. _____ Ward _____

2. FULL NAME Harris, Legna

(a) Residence No. 910 Euclid St., 2 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 7 1929

17. I HEREBY CERTIFY, That I attended deceased from 2 3 1929, to 3 7 1929, that I last saw her alive on 3 3 1929, and that death occurred, on the date stated above, at 2:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diffuse Peritonitis

2 1/2 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Toxemia
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 3-2-29.
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Chival's Salicylate
(Signed) E. H. Smith, M. B.
3/8 1929 (Address) General Hospital No. 11

*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 West Lawn DATE OF BURIAL Mar 12, 1929

20. UNDERTAKER Adkins Bros ADDRESS 2000 E. 12th

3. SEX female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 9 9

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 13, 1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>21</u>	<u>1</u>	<u>5</u>	<u>2</u>	<u>1/2</u>

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Topeka
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Denver Bell

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

12. MAIDEN NAME OF MOTHER Manfoah

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

14. INFORMANT Patient herself
(Address) 910 Euclid St.

15. FILED 3/12 1929 M. M. Crowe
REGISTRAR

VERY IMPORTANT

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**MISSOURI STATE BOARD OF HEALTH
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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. 1244
 City St. Louis (No. General Hospital) St. _____ Ward _____

2. FULL NAME Leona Harris

(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 Leaf 5. SINGLE, MARRIED, WIDOWED OR DIVORCED 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 _____
 (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 3/29 1929 M. M. Cronin REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7-1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Diffuse Peritonitis
Bilateral Salpingitis
Gonococcus Infection
 (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) H. M. Smith, 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 _____
 19____

20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

S-16766