

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

Do not use this space.

10861
40811

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 002
City Kansas City No. 1715 Virginia

File No. _____
Registered No. 1371
St. _____ Ward)

2. FULL NAME

(a) Residence. No. 1715 Virginia St. _____ Ward. _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Fe</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>L. W. Sawyers</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb. 4, 1900</u>		
7. AGE	YEARS <u>29</u>	MONTHS <u>1</u>
	DAYS <u>13</u>	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. House 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) Tenn

PARENTS	10. NAME OF FATHER <u>Henry Jones</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Adeline Williams</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Tenn</u>

14. INFORMANT. Cornelia Brackett
(Address) 1715 Virginia

15. FILED. 3/19, 1929 Wm. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 17 1929
17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1928 to March 17 1929 that I last saw her alive on March 16 1929 and that death occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis Pulmonalis
3/11/29
31 (duration) yrs. 3 mos. 5 ds.
CONTRIBUTORY (SECONDARY) Bronchial Pneumonia
beginning 12/1/28 followed by (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Tuberculosis
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Symptoms
(Signed) J. E. Donahoe M. D.
3/19, 1929 (Address) 714 Chambers Bldg.

*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 Highland Cem DATE OF BURIAL 3/21 1929

20. UNDERTAKER Watkins Bros. ADDRESS 1729 Lydia

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

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.

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Dr. J. Earle Donaldson
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