

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

Do not use this space

10870
10820

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Town Law Primary Registration District No. 1002
 City K.C. Mo. (No. Mercy Hospital)

File No. _____
 Registered No. 1320
 St. _____ Ward _____

2. FULL NAME Betty Jean Springs

(a) Residence. No. 1300 Ray, K.C.Mo. 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 F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 11, 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 8

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Deceased
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Kansas
 (STATE OR COUNTRY)

10. NAME OF FATHER Geo. M. Springs

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Warrens
 (STATE OR COUNTRY) Chillicothe, Missouri

12. MAIDEN NAME OF MOTHER Alta Rose Jenkins

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

14. INFORMANT Geo. M. Springs
 (Address) 1300 Ray Ave., K.C.Mo.

15. FILED 3/30, 1929 M. M. Cronin REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 19 1929

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1929, to March 19, 1929 that I last saw h. e. alive on March 19, 1929, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
1070 Deceased pneumonia
1000
130
 (duration) yrs. mos. ds. ✓

CONTRIBUTORY (SECONDARY) Malnutrition
 (duration) yrs. 2 mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs
 (Signed) W. H. Brewer M. D.

3/30, 1929 (Address) Mercy Hospital

*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 Park DATE OF BURIAL 3/21 1929

20. UNDERTAKER Aug, Geo. H. ADDRESS K.C.K.

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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