

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

Do not use this space.

1903

~~11089~~ ~~15004-A~~

15004-1

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township North Primary Registration District No. 1002
 City Kansas City, Mo. Gen. Hospital No. 2.

File No.
 Registered No.
 St. Ward)

2. FULL NAME

Williams Emma
 (a) Residence. No. 1819 Bellview St. 3 Ward. (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 Female
 4. COLOR OF RACE Col.
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. 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.
60
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Gen Home Work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pa. (STATE OR COUNTRY)
 10. NAME OF FATHER James Owen
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pa. (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Mary Phillips
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT James W. De Moines
 (Address) 1019 N. 1st St. Kansas City, Mo.
 15. FILED 4/4 1929 M. M. Crow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-25 1929
 17. I HEREBY CERTIFY, That I attended deceased from 3-25, 1929 to 4-2, 1929 that I last saw h. alive on 4-2, 1929 and the death occurred, on the date stated above, at 2:30 P.M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Caseous Pneumonia
Indefinite (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 19. DID AN OPERATION PRECEDE DEATH? No DATE OF
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS
3/26 (Signed) Howard W. Smith M. D.
1929 (Address) Old City 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 West Lawn Cemetery DATE OF BURIAL 4-5 1929
 20. UNDERTAKER West-Copleton Jones ADDRESS K. C. Mo

238
 22

1000

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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. 11089
 Township Kaw Primary Registration District No. 1022 Registered No. 1637
 City..... (No.....) St. Ward.....

2. FULL NAME

Emma Williams

(a) Residence. No. 1819 Bellevue St Ward..... (If nonresident give city or town and State)
 (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE B. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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 4/4 29 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2 1929

17. I HEREBY CERTIFY That I attended deceased from 3-20-29 Apr 2 10:29 that I last saw h. er alive on Apr 2 1929 and that death occurred, on the date stated 2:30 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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)....., 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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-156.7. A