

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

Do not use this space.

14732

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City

Registration District No.
Primary Registration District No.
(No. 4629 Terrace)

File No.
Registered No. 1777
St. Ward)

2. FULL NAME Daisy Frances Switzer

(a) Residence. No. 4629 Terrace 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Earl O. Switzer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 16 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 6 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) K.C.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Harry Finn

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

12. MAIDEN NAME OF MOTHER Anna Frances Durney

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

14. INFORMANT Earl O. Switzer
(Address) 4629 Terrace

15. FILED 4/14 19 29 M. M. Conroy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 12 19 29

17. I HEREBY CERTIFY That I attended deceased from 9/26 19 28, to 4/12 19 29 that I last saw h. or alive on 4/12/29 19 29, and that death occurred, on the date stated above, at 9.30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
9 23 1929
9 15 1929 (duration) 2 yrs. mos. da.
CONTRIBUTORY Pericarditis
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS? X-ray - Sputum exam.
(Signed) Ralph R. Myers M. D.
4/13 19 29 (Address) 815 Shilbut 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 DATE OF BURIAL

Mt. Moriah Apr. 15 19 29
20. UNDERTAKER ADDRESS

H. W. Gates K. C. K.

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.

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

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