

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

Do not use this space.

1822
14777

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Moan Primary Registration District No. _____
City Kansas City (No. Kansas City Genl Hosp St. _____ Ward _____)

2. FULL NAME

Mary Baldwin
(a) Residence No. 2123 E 15th St Ward 9
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 23, 1855
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 ~~73~~ 11 25

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

10. NAME OF FATHER John Vanduski
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Alabama
12. MAIDEN NAME OF MOTHER Rebecca
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Alabama

14. INFORMANT Reward Clerk
(Address) KC Genl Hosp

15. FILED 4/18, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18 1929
17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1929 to 4-18, 1929 that I last saw her alive on 4-15, 1929 and that death occurred, on the date stated above, at 12:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertension
920
100 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocardial insufficiency (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 900

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS clin - findings

(Signed) P. E. Williams, M. D.

4-18, 1929 (Address) Subt KC Genl 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 Maple Hill DATE OF BURIAL 4-19-1929

20. UNDERTAKER O. V. Mast ADDRESS K 6th

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important.

73-10

PARENTS

**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..... Registration District No. 399
 Township R. City Primary Registration District No. 1002 File No.....
 City R. City (No.....) St. (Ward) Registered No. 1872

2. FULL NAME

Mary Baldwin
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2, 3-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>73</u>	<u>10</u>	<u>25</u>		

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 4/18 1929 M M Crow REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 18 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (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)....., 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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain, forcible terms that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L.

SUPPLEMENTARY

5-14777