

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

Do not use this space.

18472

1. PLACE OF DEATH

County Jackson
Township Blue
City Little Blue Mo (No. Jackson County Home)

Registration District No. 400
Primary Registration District No. 05527

File No. _____
Registered No. 69
St. _____ Ward _____

2. FULL NAME

Maria True

(a) Residence No. 11th + Charlotte (near) Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

unknown

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

about 95

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Horse Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Don't know

(STATE OR COUNTRY)

Don't know

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Don't know

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Louisville

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT (Address)

County Home Records

15.

DATE

19

May 9 1929
W. S. James
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-7-1929

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929 to May 7, 1929 that I last saw her alive on May 5, 1929, and that death occurred, on the date stated above, at 7 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute myocardial infarction & Chronic Paralytic matris
131 nephritis

928 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Unknown (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? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam & X-ray

(Signed) W. Booker M. D.

19 (Address) 2128 Vine St

*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

Highland Cemetery

5-11-1929

20. UNDERTAKER

ADDRESS

7 Elyon + 1/2 Green Street

K. C. Mo.

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.

JUN 26 1929

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PARENTS

