

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

Do not use this space.

215352073
File No. 2073
Registered No. _____

1. PLACE OF DEATH

County Jackson Registration District No. 09
Township Kaw Primary Registration District No. 002
City Kansas City (No. 4326 Warwick Blvd.) St. _____ Ward _____

2. FULL NAME Laura Maxwell Fletcher

(a) Residence No. _____ St. _____ Ward _____ Chicago, Illinois
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Stephen Keyes Fletcher
6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 6, 1851
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 7 8

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) Lacon
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER James W. Maxwell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Pamella Owen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Rock Castle
(STATE OR COUNTRY) Kentucky

14. INFORMANT Maxwell R Fletcher
(Address) 4326 Warwick Blvd

15. FILED 6/16, 1929 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14, 1929
17. I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 14, 1929 that I last saw h.e. alive on June 14, 1929, and that death occurred, on the date stated above, at 12:30 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute indigestion
1190
950
1620 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. E. Worrall D. O. M. D.
6/14, 1929 (Address) 3831 Paseo, B.

*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 Chicago, Illinois DATE OF BURIAL OR 5/16 1929

20. UNDERTAKER Stone & McChere ADDRESS 3285
William Plagh

WRITE CLEARLY, 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.

2682
2
2
2

1000

Handwritten:
380...
in a 6...



**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 File No.....
Township..... Primary Registration District No. 1002 Registered No. 2673
City K. City (No..... St..... Ward)

2. FULL NAME

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
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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 J. S. Worrall M.D.
(Address) 3831 Base

15. FILED 9/16, 19 29 M. M. Levee
REGISTRAR am

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

with indigestion, Wrong eating of food, including canned fish.
(duration) yrs. mos. ds.
Age: Weak and irreg- ular heart
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)

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

SUPPLEMENTARY

THIS IS A PERMANENT RECORD

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
Information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-2/535