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

Do not use this space.
21729
2972

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.:
Township: Kaw — Primary Registration District No.: 3002 — Registered No.:
City: Kansas City Mo General Hospital #2 — St. — Ward)

2. FULL NAME Grant Jessie

(a) Residence. No. 948 Bell St., 1 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	Coll	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1 1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	35	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Topeka
(STATE OR COUNTRY): Kansas

PARENTS
10. NAME OF FATHER: Wm Branson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Nashville Tenn
(STATE OR COUNTRY): Tenn
12. MAIDEN NAME OF MOTHER: Ella Saunders
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): R
(STATE OR COUNTRY): Unknown

14. INFORMANT: Record Clerk
(Address) General Hosp #2

15. FILED 7/8, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6th 27th 1929

17. I HEREBY CERTIFY, That I attended deceased from 6 1, 1929 to 6-27, 1929 that I last saw her alive on 6-27, 1929 and that death occurred, on the date stated above, at 7 40 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pneumonia
22A Phthisis
93D (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Myocardial Weakness (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clin & Lab

(Signed) H M Smith, M. D.
6/28, 1929 (Address) Genl Hosp No 2

*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
Blue Ridge Lawn	7/9 1929
20. UNDERTAKER	**ADDRESS**
West Appleton & Jones	1600 E 19

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.

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