

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

Do not use this space.

24790

3202

1. PLACE OF DEATH

County Jackson
Township Kan
City N. E. Mo. (No. 4100 Anderson)

Registration District No. 399
Primary Registration District No. 1002

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

2. FULL NAME

Molley Lee Haley
(a) Residence. No. 4100 Anderson St. 10 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 Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-9-1868
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 61 0 15

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

9. BIRTHPLACE (CITY OR TOWN) Leavenworth
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER David Siche

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Platts Co
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Elizabeth

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

14. INFORMANT Louis Haley
(Address) 4100 Anderson

15. FILED 7/25 19 29 M. M. Crowe REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-24-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to July 24 1929 that I last saw her alive on July 23 1929 and that death occurred, on the date stated above, at 7 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis (13)
and Endocarditis

(duration) yrs. mos. ds. _____
CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
(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) Garst Nelson M. D.

7-24-1929 (Address) 1812 Fed Res 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 Memorial Park DATE OF BURIAL 7-26 19 29

20. UNDERTAKER Mrs. C. S. Foster ADDRESS City

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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Handwritten mark or signature

Vertical text or stamp