

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

Do not use this space.

27734
3423

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Kansas City (No. 1616 East 67th St St. _____ Ward)

File No. _____
 Registered No. _____

2. FULL NAME Mrs. Margaret Calloway
 (a) Residence. No. 1616 East 67th St St. 15 Ward. _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 8 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 Wm. T. Calloway

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 24, 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 11 16

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) (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Wm. Kelly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Polly Grass

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

14. INFORMANT Mrs J. B. Young
 (Address) 540 a. e. line

15. FILED 8-10-1929 M. M. Crowe REGISTRAR
asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 10 19 29

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 9, 1929 that I last saw him alive on Aug 9, 1929, and that death occurred, on the date stated above, at 1:35 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
107 (duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY) Bronchial pneumonia
 (duration) yrs. mos. ds. 6

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Smear Findings
 (Signed) J. H. Owens, M. D.

Aug 10, 19 29 (Address) 1034 Realth Home S. Mo

*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 Rich Hill Missouri DATE OF BURIAL 8-11-29 19

20. UNDERTAKER R. V. LINDSEY & SONS Inc ADDRESS 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.

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