

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

Do not use this space.

27832

3524

**1. PLACE OF DEATH**

County Jackson  
Township Clay  
City Kansas City (No. Trinity Hospital)

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs Mary M. Ross

Nevada Mo

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12, 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
35 3 5

**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) Butler, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. A. Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Butler, Mo.

12. MAIDEN NAME OF MOTHER Aberta Snyder

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

14. INFORMANT Thomas J. Ross  
(Address) Nevada, Mo.

15. FILED 8-17-24 911 M. Crowl  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-17 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug-16 1924 to Aug-17 1924  
that I last saw her alive on Aug-17 1924, and that death occurred, on the date stated above, at 10 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Nephritis  
13 (duration) several days yrs. mos. ds.

CONTRIBUTORY (SECONDARY) unknown  
(duration) \_\_\_\_\_ yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Urinal  
(Signed) Dr. U. Stevens M. D.  
8/17 1924 (Address) 910 Reeds 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 Nevada, Mo DATE OF BURIAL 8/17 1924

20. UNDERTAKER Greenman Mortuary  
104 W. 42nd St. ADDRESS

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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