

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 2955 Flora)

File No. 28031
Registered No. 3739
St. _____ Ward _____

2. FULL NAME Elizabeth P. Ives

(a) Residence No. 2955 Flora St. 4 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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas N. Ives</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 14, 1851</u>		
7. AGE	YEARS	MONTHS
	<u>78</u>	<u>2</u>
		<u>17</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at Home</u> (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) Delaware

PARENTS	10. NAME OF FATHER <u>John E. Hayes</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not known</u>
	12. MAIDEN NAME OF MOTHER <u>Mrs. Mercer</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not Known</u>

14. INFORMANT J. M. Johnson
(Address) 2955 Flora

15. FILED 9-3, 1929 M. M. Brown
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 31, 1929

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929 to Aug 31, 1929 that I last saw her alive on Aug 31, 1929, and that death occurred, on the date stated above, at 10:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis with arterio sclerosis

several (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Arterio (duration) 0 yrs. 0 mos. 0 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & laboratory

(Signed) Wm. Brown, M. D.

9-3, 1929 (Address) 814 Arlyle Blvd.

*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 _____

Mt. Washington Bur 9-3-1929

20. UNDERTAKER _____ ADDRESS _____

Stine & McClure 3235 Hillman Plaza

127