

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

Do not use this space.

30852
3876

1. PLACE OF DEATH
 County Jackson Registration District No. 1002
 Township Franklin Primary Registration District No. _____
 City Kansas City No. 1516 (Virginia) St. _____ Ward _____

2. FULL NAME Mollie Counts
 (a) Residence No. 1516 Virginia No. 2 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

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 8 8

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 _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/9/29

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1929 to June 29 1929 that I last saw him alive on June 15 1929 and that death occurred, on the date stated above, at 9:15 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Ulcer

48 (duration) yrs. mos. ds.
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CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Georgia
 (STATE OR COUNTRY)

10. NAME OF FATHER William Jones

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

12. MAIDEN NAME OF MOTHER Minnie Cook

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

14. INFORMANT Samuel Counts
 (Address) 1516 Virginia

15. FILED 9/14, 1929 M. W. Crowe
axi REGISTRAR

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? none

(Signed) [Signature] M. D.
9/12, 1929 (Address) 1512 N. Oak St

*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 Little Rock, Ark DATE OF BURIAL 9/15 1929

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lyda

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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S. H. Thompson.