

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

Do not use this space.

33656

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. Lake side Hospital)
 St. _____ Ward _____

2. FULL NAME SCOTT Pernie Eve
 (a) Residence. No. 2017 East 82 nd Terrace 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 Lacy E Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 15 1908

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
21 11 16

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) Home

(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Portuna
 (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER John C White

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Co per Coun
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Nellie Snyder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Laclead Coun
 (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. Nellie R White
 (Address) 2017 E 82 nd Terrace

15. FILED 10/1, 19 29 M. M. Cronin
 REGISTRAR Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 19 29, to Oct 1, 19 29, that I last saw him alive on Oct 1, 19 29, and that death occurred, on the date stated above, at Home.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute albuminuria
146 Urannia
143 B (duration) yrs. mos. 2 ds.

CONTRIBUTORY Pregnancy
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
 (PLACE AT PLACE OF DEATH) 2017 E 82 nd Terrace

DID AN OPERATION PRECEDE DEATH? No DATE OF same
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab
10/1 (Signed) George J Cronin, M. D.
 (Address) Lakeside Hospital

*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 Versailles, Missouri DATE OF BURIAL Oct 3, 1929

20. UNDERTAKER Mrs. M. M. Cronin ADDRESS Kansas City
Assn

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 very important.

RECORD

PERMANENT

1

9237

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City Trans City (No.....)

Registration District No. 399
Primary Registration District No. 1902

File No. 4099
Registered No. 4090
St. Ward)

2. FULL NAME

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 15 - 1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 11 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT.....
(Address)

15.

FILED 10/11, 1929 M. M. Crowe
Kost REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH SPACING INK--THIS IS A VITAL 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33656