

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

Do not use this space.

33994

4357

1. PLACE OF DEATH

County Jackson Registration District No. 1002
Township Law Primary Registration District No. _____
City Danvers City (No. 1618) Garfield St. _____ Ward _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 7678 Garfield 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 29-1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 11 19

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) Lexington Mo
(STATE OR COUNTRY) _____

10. NAME OF FATHER Erwin Necker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Osage Springs
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Ermine Necker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lexington Mo
(STATE OR COUNTRY) _____

14. INFORMANT Miss Edith Gardner
(Address) 7678 Garfield

15. FILED 10/21 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1929 to Oct 19 1929 that I last saw her alive on Oct 18 1929 and that death occurred, on the date stated above, at 4:15 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic encephalitis
following influenza 12 yrs ago.
78 B (duration) 12 yrs. mos. ds.

CONTRIBUTOR (SECONDARY) IB (duration) _____ yrs. mos. ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS Clinical diagnosis
(Signed) Darwin Delap M. D.
OCT 20 '29 (Address) 509A Wirthman Bldg. KANSAS CITY 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 Lexington Mo DATE OF BURIAL 10/27/29

20. UNDERTAKER F O'Donnell ADDRESS 3256 Bldwy

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.

