

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

Do not use this space.
33905
4358
File No. _____
Registered No. _____
St. _____

\$ 99

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Jones Primary Registration District No. 1002
City Kansas City (No. Don Hospital #2) St. Flour

2. FULL NAME

(a) Residence. No. 2005 1118 Charlotte St. E 2 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 11 yrs. mos. da. - How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Negro 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) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>41</u>				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Clarksville Texas
(STATE OR COUNTRY)

10. NAME OF FATHER Moses Larson

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

12. MAIDEN NAME OF MOTHER Hester Weaver

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

14. INFORMANT found clerk
(Address) R 6 mo

15. FILED 10/22/29 M. M. Crane
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-24, 1929, to 10-10, 1929, that I last saw h. h. alive on 10-10-29, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Enteritis
Myocardite. Chronic
93 C
91 B (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) POW (duration) _____ yrs. _____ mos. _____ 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? M. M. Smith, M. D.
(Signed) _____

10/22/29 (Address) City Hospital #2

* 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 Blue Ridge Lawn Cem. DATE OF BURIAL 10/22/29

20. UNDERTAKER West W. P. Phipps, Inc. ADDRESS 1600 E 19th

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.

MARGIN RESERVED FOR BINDING

