

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

Do not use this space.

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1127

**1. PLACE OF DEATH**

County Jackson  
Township Jean  
City Kansas City (No. 1002)

Registration District No. 399

Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Stevens Maggie  
(a) Residence No. 1723 Mintgale St., 11 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-1-1910

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>19</u>	<u>4</u>	<u>24</u>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housework  
(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) Mo.

**10. NAME OF FATHER**

Riley Stevens

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**12. MAIDEN NAME OF MOTHER**

Louise Schaefer

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**14.**

INFORMANT Debra Clark  
(Address) 7 C. Genl Hosp

**15.**

FILED 10/26, 1929

M. M. Crow  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 25 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-21, 1929 to 10-25, 1929 that I last saw her alive on 10-25, 1929 and that death occurred, on the date stated above, at 7:30 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic diffuse nephritis

131 duration yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

1270 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 Plus Findings

(Signed) E. Williams, M. D.

10-25-1929 (Address) Subt 7 C. Genl Hosp

\*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**

Cremated

10-26-1929

**20. UNDERTAKER**

**ADDRESS**

Mrs. L. Foster

City

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.

Dr. C. H. Case

1217 1/2 14th St.