

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

Do not use this space.

34015

4468

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Kenn Primary Registration District No. \_\_\_\_\_  
 City N.P. Mo. (No. St. Joseph Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

Jennie Paradise  
 (a) Residence. No. 1040 Monroe St. 12 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) Jan-15-1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>61</u>	<u>57</u>	<u>9</u>	<u>12</u>

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Housekeeper  
 (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) Missouri

PARENTS	10. NAME OF FATHER <u>John Hubert</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Helia James</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo.</u>

14. INFORMANT J. W. James  
 (Address) 1213 Clay Co. No. K.P.R.

15. FILED 10/29/29 M. M. Crewe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 27, 1929 that I last saw him alive on 10/30/29, and that death occurred, on the date stated above, at 12/30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Surgical Shock  
47 following Hysterectomy  
Carcinoma of uterus  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH Wm. Kern

DID AN OPERATION PRECEDE DEATH? no DATE OF Oct 26 29

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS clinical  
 (Signed) J. W. James, M. D.  
10/28/29 (Address) 734 Agg

\*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 Maple Hill DATE OF BURIAL Oct-30, 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MAKING RESERVED FOR BINDING

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.

V. 9, NO. 2.

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wie 9581