

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

Do not use this space.

37147
4616

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. General Hosp # 2)

Registration District No. 1002
Primary Registration District No. General Hosp # 2

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

2. FULL NAME

(a) Residence. No. 1526 Lydia St. 2E 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 Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 10, 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
40 | 9 | 26

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Arkansas

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Fred Legater

(Address) 1526 Lydia

15. FILED 11/9 '39 M. W. Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/6 1939

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1939, to Nov 6, 1939 that I last saw her alive on Nov 6, 1939, and that death occurred, on the date stated above, at 3:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
10 yrs (duration) yrs. mos. 3 ds.

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

18. WHERE WAS DISEASE CONTRAICTED At home
IF NOT AT PLACE OF DEATH _____

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

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) H. M. Smith, M. D.

11/6 '39 (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 Fort Smith, Ark. DATE OF BURIAL 11/9 1939

20. UNDERTAKER Watkins Bros ADDRESS 1729 Lydia

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.

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