

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.

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

Do not use this space.

37224

1. PLACE OF DEATH

County Jackson Registration District No. 3890  
Township Blue Primary Registration District No. 1002  
City Leeds, mo. (No. Leeds tuberculosis hospital)

File No. 304094  
Registered No. 4094  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Julia Anderson  
(a) Residence No. 544 Cherry St. T.B. Hospital

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 23, 1898

7. AGE 31 YEARS MONTHS 0 DAYS 15 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

9. BIRTHPLACE (CITY OR TOWN) Little Rock Ark. (STATE OR COUNTRY)

10. NAME OF FATHER Living Wright

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

12. MAIDEN NAME OF MOTHER Julia Wright

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

14. INFORMANT T.B. Hospital (Address) Leeds, mo.

15. FILED 11-16, 1929 M. M. Crowe REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1929, to Nov. 10th, 1929, that I last saw her alive on Nov. 9, 1929, and that death occurred, on the date stated above, at Nov. 10th 2am.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Pulmonary Tuberculosis  
(duration) 0 yrs. 0 mos. 24 ds.

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

18. WHERE WAS DISEASE CONTRACTED unknown  
IF NOT AT PLACE OF BIRTH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Chemical Laboratory

(Signed) Edwin H. Kel M. D.

Nov 11, 1929 (Address) 1830 Vine St K.C. 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 Blue Ridge Lawn DATE OF BURIAL 11-16 1929

20. UNDERTAKER Went Appleton & Jones ADDRESS 1600 E 19th

Geo Anderson

444 Cherry St