

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

Do not use this space.

37263

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 37263
 Township Kear Primary Registration District No. 1003 Registered No. 4733
 City N. E. Mo. (No. Vineyard Park Hosp) St. _____ Ward _____

2. FULL NAME

Jennie B. Drayer
 (a) Residence No. 3426 St. John St. 9 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 F 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) Oct-5-1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
46 1 14

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) Miami
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Geo. B. Vance

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

12. MAIDEN NAME OF MOTHER Mary Kier

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

14. INFORMANT Helena Virginia Drayer
 (Address) 3426 St. John Ave

15. FILED 11/19/29 M. M. Crowe
 REGISTRAR Apr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-19-1929

17. I HEREBY CERTIFY That I attended deceased from November 7, 1929 to Nov. 19, 1929
 that I last saw her alive on Nov. 18, 1929 and that death occurred, on the date stated above, at 2:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Streptococci septicemia
from empyema of right
pleurum

(duration) _____ yrs. _____ mos. 11 ds.

CONTRIBUTORY (SECONDARY) Infection of right pleurum
 (duration) _____ yrs. _____ mos. 11 ds.

18. WHERE WAS DISEASE CONTRACTED

1. NOT AT PLACE OF DEATH
 2. IN OPERATION PRECEDE DEATH. yes DATE OF Nov. 17, 1929

3. WAS THERE AN AUTOPSY? No
 4. WHAT TEST CONFIRMED DIAGNOSIS Clinical, Laboratory
 (Signed) Samuel Doegelin M. D.

Nov. 19, 1929 (Address) 604 Commerce Bldg.

*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 St. Washington DATE OF BURIAL Nov-21, 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS N. E. Mo.

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.

RECORD

1870- 8-1

59 3 18

~~W. S. ...~~

80-7 Commercial

4173

~~8075 ...~~

4pm