

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

Do not use this space.

40860

**1. PLACE OF DEATH**

County Jackson  
Township Lea  
City Hayward City

Registration District No. 399

Primary Registration District No. 6148 Park

File No. 5200  
Registered No. 5200  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 6148 Park St., 15 Ward.

(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 Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louie B. McKemie

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 29 - 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, .....hrs. or .....min.
	<u>26</u>	<u>8</u>	<u>21</u>	

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) Davis City  
(STATE OR COUNTRY) Iowa Mo

10. NAME OF FATHER J. H. Jarvis

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Louie B. McKemie  
(Address) 6148 Park

15. FILED 12 29 19 29 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 20 1929

17. I HEREBY CERTIFY, That I attended deceased from March 31 1929 to March 20 1929 that I last saw her alive on March 20 1929, and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Subarachnoid of Lungs

2-3A (duration) 1 yrs. 9 mos. - ds.

CONTRIBUTORY (SECONDARY) 31 (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? Sputum, X rays  
(Signed) E. M. Grant, M. D.

12/21, 1929 (Address) 2544 Olive

\*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 Mount Washington DATE OF BURIAL Dec 23 1929

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

WRITE PLAINLY, WITH OUTFRADING INSTRUMENTS 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.

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