

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

Do not use this space:

40950

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 5357
 Township Blue Primary Registration District No. 1063 Registered No. _____
 City Leeds (No. Laboratory Hospital) St. _____ Ward _____

2. FULL NAME

Clarke Octavia
 (a) Residence, No. 1126 Woodland St., 2 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 <u>Female</u>		4. COLOR OR RACE <u>Colored</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 4, 1907</u>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.	
<u>22</u>		<u>1</u>	<u>23</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>House maid</u>					
(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) <u>Texas</u>					
10. NAME OF FATHER <u>Carroll Joe</u>					
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>					
12. MAIDEN NAME OF MOTHER <u>Little Minerva</u>					
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>					
14. INFORMANT <u>F.C.T. B. Drapp</u> (Address) <u>Mabel Smith</u>					
15. FILED <u>1/28, 1929</u> <u>1126 Woodland</u> <u>M.M. Crowe</u> REGISTRAR <u>ass't</u>					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 27 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 26, 1929 that I last saw him alive on Dec 26, 1929, and that death occurred, on the date stated above, at 6:06 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pulmonary Tuberculosis
2.3A

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED unknown
 *IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical Laboratory
 (Signed) Edwin H. ... M. D.
Dec 28, 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 <u>Honeygrove Tex</u>	DATE OF BURIAL <u>12 - 28 - 29</u>
20. UNDERTAKER <u>A.B. Moore</u>	ADDRESS <u>1820 E 18</u>

WRITE PLAINLY, WITH UNFADING INK---THIS 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.

