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

Do not use this space.

1328

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.:

Township: Kaw — Primary Registration District No.: 1002 — Registered No.: 320

City: Kansas City (No. Kansas City General Hosp. St. ... Ward)

2. FULL NAME Maud Geary

(a) Residence. No. 215 Lincoln Ave St., / 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Lost Know

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
52 yr			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lab.
(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) Lost Know

PARENTS

10. NAME OF FATHER Lost Know

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

12. MAIDEN NAME OF MOTHER Lost Know

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

14. INFORMANT Supt K C Genl Hosp
(Address) Kansas City Mo

15. FILED Jan 22 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930 to Jan 20 1930 that I last saw her alive on Jan 20, 1930, and that death occurred, on the date stated above, at 6:00 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococcic Meningitis

20 H

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)

(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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Clin Lab Find & Autopsy

(Signed) F E Williams, M. D.

1-20, 1930 (Address) Gen Hospt 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: Leeds — DATE OF BURIAL: 1/23 1930

20. UNDERTAKER: O O Mast — ADDRESS: 1915 East 15

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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