

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

Do not use this space.

1382

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. 515 Tracy)

Registration District No. 30
Primary Registration District No. 10

File No. 374
Registered No. 374
St. _____ Ward _____

2. FULL NAME

Emma Clark
(a) Residence No. 515 Tracy St. 1 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. _____ mos. _____ da. _____ 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

Female

4. COLOR OR RACE

Col.

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

Married

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

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

July 17, 1877

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>52</u>	<u>6</u>	<u>6</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)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Jackson Pollard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Sarah Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

(Address)

James Clark
515 Tracy

15. FILED

19 30

M. M. Browne
Assr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

1/23 1930

17.

I HEREBY CERTIFY that I attended deceased from Jan 17 1930

that I last saw her alive on Jan 17 1930 and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobular pneumonia

CONTRIBUTORY (SECONDARY)

107/01/W (duration) yrs. _____ mos. _____ ds. _____
La Grappe
(duration) yrs. _____ mos. _____ ds. _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) L. W. Brown M. D.

(Address) 1705 E 12

*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

DATE OF BURIAL

Richmond Mo

1/27 1930

20. UNDERTAKER

ADDRESS

Hatkins Bldg.

1729 Lyden

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.

G. H. Brown.