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

Do not use this space.

5077

1. PLACE OF DEATH
County of Jackson — Registration District No. 399 — File No. 734
Township Kansas — Primary Registration District No. 2 — Registered No.
City Kansas City — No. Gent Hosp #2 — St. — Ward)

2. FULL NAME Rosa Neal
(a) Residence. No. 2435 Bellefontaine 11 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 Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't Know
7. AGE About — YEARS 73 — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(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) Kentucky

PARENTS
10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT Record Clerk
(Address) Gen. Hosp. #2
15. FILED 2/17, 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1930
17. I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1930, to Feb 30, 1930 that I last saw her alive on Feb 12, 1930, and that death occurred, on the date stated above, at 4 50 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Endometritis.
936
1396
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (SECONDARY) 903
(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?
(Signed) H. M. Smith, M. D.
2/13, 1930 (Address) Gen. Hosp. #2

*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 Shy Ridge Lawn — DATE OF BURIAL 2-17 1930
20. UNDERTAKER J. W. A. H. Fichlin — ADDRESS 1209 Vine

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.