

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

Do not use this space.

5194

1. PLACE OF DEATH  
 County Jackson Registration District No. 1 File No. 302  
 Township 1st Registration District No. 1 Registered No. 302  
 City St. Joseph St. 2 Ward 2

2. FULL NAME White, Grace  
 (a) Residence No. 1314 Virginia St. 2 Ward 2  
 (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.

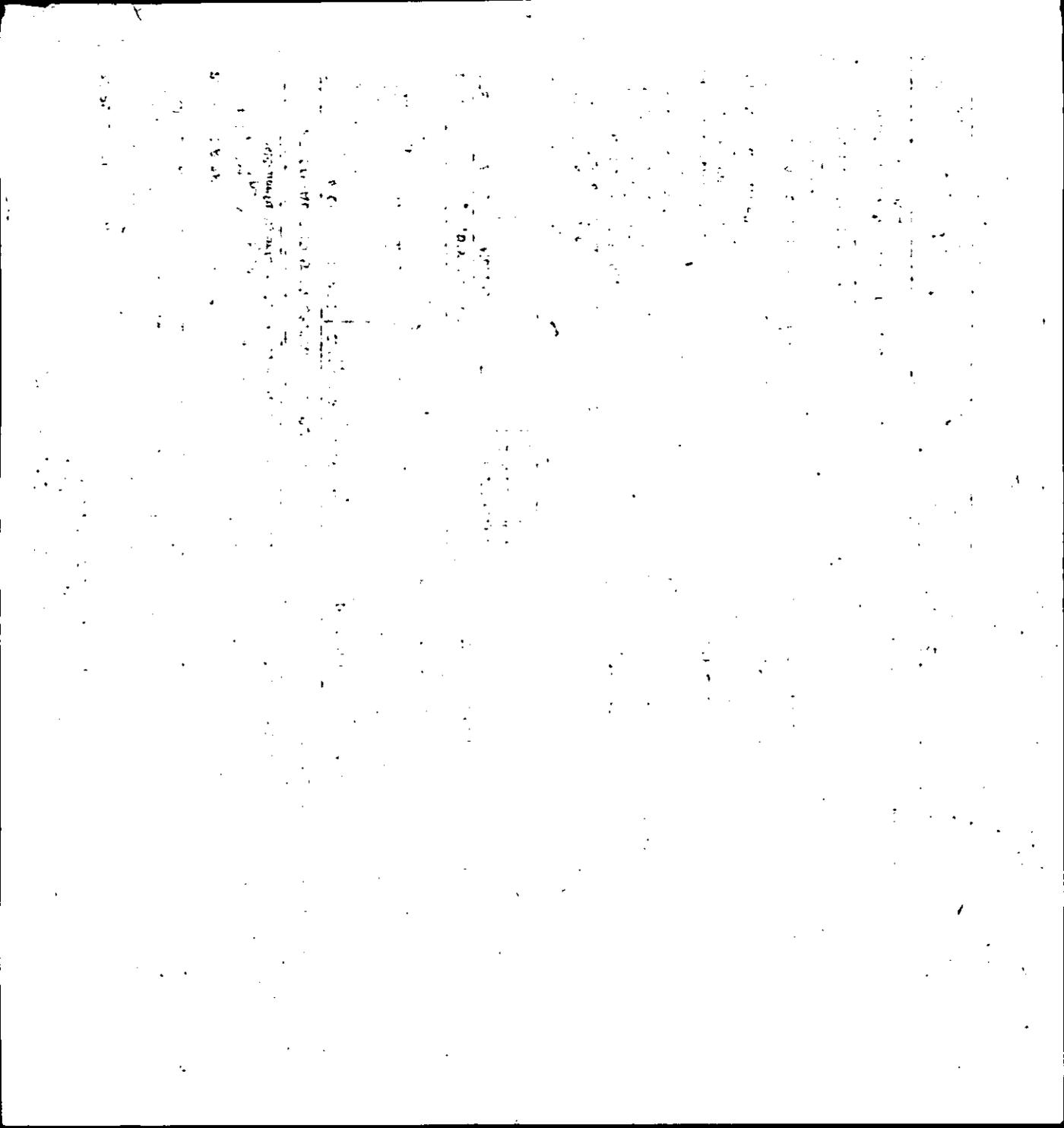
**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE negro  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Craig  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 1908  
 7. AGE YEARS MONTHS DAYS 22 1 18 If LESS than 1 day, hrs. of 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) Symphony Kan  
 10. NAME OF FATHER Wm. Bean  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Delaware  
 12. MAIDEN NAME OF MOTHER Myrtle Stral  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Delaware  
 14. INFORMANT (Address) Wm. J. Crowe  
 15. FILED 24-30 1930 M. J. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-21-30  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Accidental automobile  
fractures  
multiple injuries  
 CONTRIBUTORY (SECONDARY) Jackson Co. Mo. (duration) yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH...  
 19. DID AN OPERATION PRECEDE DEATH... DATE OF...  
 WAS THERE AN AUTOPSY? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? autopsy  
 (Signed) Dr. ... M. D.  
 (Address) St. Joseph  
 \*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 Delphi Home DATE OF BURIAL 2-24-30  
 20. UNDERTAKER Wm. J. Crowe ADDRESS 1709 Kan

2330  
19



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 399 File No. 5194  
 Township..... Primary Registration District No. 1002 Registered No. 852  
 City Kansas City (No.....) St. .... Ward (.....)

**2. FULL NAME** .....

Alice Craig

(a) Residence. No. .... 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 B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 2/24, 1930 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 21 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19....., 19....., and that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

auto accident  
Jackson Co. Mo. (duration) yrs. mos. ds.  
 CONTRIBUTORY alcohol with (SECONDARY) both auto (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)....., M. D.  
 , 19 (Address)

\*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1886  
201

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