

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

Do not use this space.

8687

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Kansas City (No. Trinity Hospital) St. _____ Ward _____

File No. 1104
 Registered No. _____

2. FULL NAME Florence C. Tow

(a) Residence. No. President Hotel St. 1 Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10, 1900

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	29	7	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Austin
 (STATE OR COUNTRY) Minnesota

10. NAME OF FATHER Lewis Tow
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Norway
 (STATE OR COUNTRY) Iowa
 12. MAIDEN NAME OF MOTHER Lena Nelson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Leroy
 (STATE OR COUNTRY) Minnesota

14. INFORMANT Mrs Ruth Bergh
 (Address) Cedar Rapids, Iowa

15. FILED 3/9 20 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/8 1930

17. Deputy Coroner
 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:

Bichloride, a poison, suicide
1630

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

CONTRIBUTORY (SECONDARY) 166
 (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 Autopsy

(Signed) Stanley M. Albee, M. D.

3/8, 1930 (Address) Deputy Coroner

*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

Cedar Rapids, Iowa 3-9-30 19

20. UNDERTAKER ADDRESS

Freeman Mortuary

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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