

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

Do not use this space.

8722

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 10
 City K.C. Mo. (No. 526 Denver) St. Mo. Ward

File No. _____
 Registered No. 1000 St. _____ Ward

2. FULL NAME

Frances Isabelle Hayward

(a) Residence. No. 526 Denver St. 10 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 Fe 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23-1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 6 18

8. OCCUPATION OF DECEASED

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

Johnson Co., Kansas

10. NAME OF FATHER

Jeb Meek

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

Ohio

12. MAIDEN NAME OF MOTHER

Sarah Sullivan

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

Illinois

14. INFORMANT

Mrs. Sarah Anderson
 (Address) 526 Denver Avenue

15. FILED

Mar 30 1930 M. M. Crowe
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb, 11-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-7-30 to 2-11-30 that I last saw her alive on 2-10-30 and that death occurred, on the date stated above, at 8:25 Am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
93C (duration) 1 yrs. 1 mos. ds.
 CONTRIBUTORY Chronic Nephritis
 (SECONDARY) (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

129 A
 IN NOT A PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

31 (Signed) M. O. Kehon M. D.
1/2 1930 (Address) Kansas City 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

DATE OF BURIAL

Mt. Meriah Feb 13, 1930

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster K.C. Mo.

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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Dr. 111
412 Chambers Bldg. Hz. 5418
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