

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

Do not use this space.

8768

**1. PLACE OF DEATH**

County..... Jackson Registration District No. 399  
Township..... North Primary Registration District No. 1002  
City..... No. 370 (No. 2114 Benton)

File No. ....  
Registered No. 1146  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 2114 Benton St., 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 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) Dec 21 29  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
— 2 23

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work..... Child  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... KC Mo  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER Ora Silvers  
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... Mo.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Dorothy Bertaux  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... Mo  
(STATE OR COUNTRY)

14. INFORMANT Ora Silvers  
(Address) 1118 Prospect

15. FILED 3/14, 1930 M. M. Bonnie REGISTRAR  
Assr

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 14 1930  
17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1930 to Mar 13 1930 and that I last saw him alive on 13 1930 and that death occurred, on the date stated above, at 6:35a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
secondary to acute  
nasopharyngitis  
104H (duration) yrs. mos. 3 da.  
CONTRIBUTORY (SECONDARY) 104H (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY?..... no  
WHAT TEST CONFIRMED THE DIAGNOSIS?..... Chined Symptom  
37 (Signed) Phillip S. Ashford M. D.  
14. 1930 (Address) 400 Argyle Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from TOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial pk DATE OF BURIAL Mar 17 1930

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

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.

Dr.

Astorque

400 Apple & Blodg. Mai 0625  
Nw. Armour & Tracy 1/2 2700

Myself

2 20 5 30