

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

Do not use this space.

9009

**1. PLACE OF DEATH**

County Jackson Registration District No. 300  
 Township Green Primary Registration District No. \_\_\_\_\_  
 City Kansas City No. Kansas City Gen. Hosp St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 1391  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Dorothy Clark  
 (Usual place of abode) 1402 ~~Street~~ 3939 Kenwood (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jun 25 1912</u>		
7. AGE	YEARS	MONTHS
	<u>18</u>	<u>2</u>
		<u>3</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Clerk</u>		
(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) Kansas

10. NAME OF FATHER H.M. Clark

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

12. MAIDEN NAME OF MOTHER Minnie Payne

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

14. INFORMANT Reina Clark  
 (Address) R.C. Gen'l Hosp

15. FILED 3/30, 1930 M.M. Crowe  
 REGISTRAR  
Assn

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-28-1930

17. I HEREBY CERTIFY, That I attended deceased from 3-17, 1930, to 3-28, 1930 that I last saw him alive on 3-28, 1930 and that death occurred, on the date stated above, at 2:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Peritonitis - following  
Cholera  
150A (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) 146 (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) P. Williams, M.D.  
3-28-1930 (Address) Sub R.C. Gen'l Hosp

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill DATE OF BURIAL 3-31-30  
 19

20. UNDERTAKER A.V. Mast ADDRESS 1915 E 15

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.

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 2  
 31

MARGIN RESERVED FOR BRIDING

U. S. S. O. L.

