

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

Do not use this space.

9025

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 1407  
 Township Raw Primary Registration District No. 1092 Registered No. 1407  
 City Kansas City, General Hospital #2 St. 2 Ward)

**2. FULL NAME**

Leah Conway  
 (a) Residence. No. 811 1/2 Brooklyn Ward. (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 col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 3, 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
41      1      26

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

10. NAME OF FATHER Samuel Swann

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

12. MAIDEN NAME OF MOTHER Jane Smith

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

14. INFORMANT Neva Swann  
 (Address) 1207 E. Armour

15. FILED 3/31, 1930 M. M. Crowe  
 REGISTRAR Crowe

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-29-30

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:**

Chronic Hypertens  
Chronic Interstitial  
 CONTRIBUTORY (SECONDARY) Hypertens (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 yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy  
 (Signed) M. M. Crowe M. D.

1919 (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 Harder No DATE OF BURIAL Mar. 31, 1930

20. UNDERTAKER Adkins Bros ADDRESS 2002 E 12th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

V. 5, No. 2.

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