

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

Do not use this space.

12565

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City

Registration District No. 3000

Primary Registration District No. 1003

File No. 1148
Registered No. 1148
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Nola Smith St. 9 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 9 - 1846

7. AGE YEARS 83 MONTHS 6 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. J. W. No. 1 Crowe
(Address) 209 North Missouri K.C. Mo

15. FILED 4/4 1930 M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3rd 1930

17. 10 I HEREBY CERTIFY, That I attended deceased from March 10th 1930, to April 3rd 1930 (that I last saw h. or alive on April 3rd 1930, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Myocardial Regurgitation with Shock

131 92A (duration) _____ yrs. _____ mos. _____ da.
95B

CONTRIBUTORY (SECONDARY) Chronic Nephritis

(duration) 3 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Don't know
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical
(Signed) G. B. S. S. S. M. D.

4/4 1930 (Address) 638 Tolson

*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 Pleasant Hill Missouri DATE OF BURIAL 4-5 1930

20. UNDERTAKER John J. Sheehane ADDRESS 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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