

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

Do not use this space.

12697

1624

1. PLACE OF DEATH

County Jackson
Township KAW
City Kansas City, Mo

Registration District No. 399
Primary Registration District No. 1002
(No. 1815 Indiana Ave.)

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME Mrs. Alice Victoria Ross

(a) Residence. No. 1815 Indiana Ave. 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. 1 mos. 14 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 (write the word) <u>widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/23/1849

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>81</u>	<u>0</u>	<u>18</u>	

8. OCCUPATION OF DECEASED

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

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

PARENTS	10. NAME OF FATHER <u>Perry Lucas</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
	12. MAIDEN NAME OF MOTHER <u>Libbey Hargrove</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kansas</u>

14. INFORMANT Charles A. Ross
(Address) 3923 Campbell St

15. FILED 4/12/30 M. M. Crowe
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1930, to Apr. 11, 1930 that I last saw him alive on Apr. 11, 1930 and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchitis
23A
106A

CONTRIBUTORY (SECONDARY) Chronic Tuberculosis
(duration) 20 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.

(Signed) [Signature], M. D.

4/11, 1930 (Address) 1503 Wald Keyes Bldg.

*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 Lawson, Missouri DATE OF BURIAL 4/13/30

20. UNDERTAKER Freeman Mortuary 104 W 42nd St. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1303 Lake California - 164

STATE OF CALIFORNIA
COUNTY OF SAN FRANCISCO

Should be stated

USE OF DEATH
Every item of information
be certified

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County
Township *X. City*
City *X. City* (No.) St. Ward

Registration District No. *399*
Primary Registration District No. *1002*

File No.
Registered No. *1624*
St. Ward

2. FULL NAME

(a) Residence. No. St. 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 *F* | 4. COLOR OR RACE *W* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Wid*

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

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

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

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED *4/12 30* 19... *M. M. Crowe* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 11* 19 *20*

17. I HEREBY CERTIFY, That I attended deceased from 19... to 19... that I last saw h. die on 19... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchitis
CONTRIBUTORY *Chronic Tuberculosis* (duration) yrs. mos. ds.
(SECONDARY) *A. Lung* (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.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) M. D.
, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

31

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