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

Do not use this space.

File No. 12755

Registered No. 1052

1. PLACE OF DEATH

County: Jackson — Registration District No. 399

Township: Kaw — Primary Registration District No. 1002

City: Kansas City (No. 4319 Madison St. Ward)

2. FULL NAME Mary Ann Lloyd

(a) Residence. No. 4319 Madison St., 7 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Fe	Wh	Wid.

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF John Lloyd

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife 198 821
(b) General nature of industry, business, or establishment in which employed (or employer): 97
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) N.Y.

PARENTS

10. NAME OF FATHER E. Watson

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

12. MAIDEN NAME OF MOTHER Mary E. Hodgkins

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

14. INFORMANT Mrs. Anna Regan
(Address) 4319 Madison

15. FILED 4/17, 19 30 M. M. Lerowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 16 19 30

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to April 16, 1930 that I last saw h. alive on April 15, 1930, and that death occurred, on the date stated above, at 2.10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic Lobar Pneumonia
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Hemiplegia, Hypertension - Arteriosclerosis
(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?
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) Eugene H. Ferguson M.D.
4/17, 19 30 (Address) 1810 W 45th

*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: Forest Hill — DATE OF BURIAL: Apr. 18 19 30

20. UNDERTAKER: Gates Funeral Home — ADDRESS: K.C.K.

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.

MARGIN RESERVED FOR BINDING