

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

Do not use this space.

15992

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. Wesley Hospital)

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1390  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Olive May Ensign

(a) Residence. No. Healy, Kansas St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF E. M. Ensign  
(OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/24/1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	44	2	8	

8. OCCUPATION OF DECEASED House wife

- (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) Kansas  
(STATE OR COUNTRY)

10. NAME OF FATHER Barnett Ball

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

12. MAIDEN NAME OF MOTHER Mrs. Libby Van-winkle

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

14. INFORMANT Mr. E. M. Ensign  
(Address) Healy, Kans

15. FILED 5/2 30 M. M. Crowe  
REGISTRAR  
Ans

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/2/30 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-1-30 to 5-2-30 that I last saw her alive on 5-2-30, and that death occurred, on the date stated above, at 9-30-9 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Coronary Embolism  
1920  
940 (duration) yrs. mos. ds.

CONTRIBUTORY Ventral Hernia  
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5-2-30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) B. B. Powell M. D.

5-2-1930 (Address) 926 Mc Gee

\*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 to HEALY, KANSAS. DATE OF BURIAL 5/5/30 1930

20. UNDERTAKER Mellody McGilley Co. 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.

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

