

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

Do not use this space.

16234

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
1002

Primary Registration District No. 6217 Rock Hill Road

File No. 2132
Registered No. 2132
St. _____ Ward _____

2. FULL NAME Mrs. Nannie Reed Rings

(a) Residence No. 6217 Rock Hill Road St. 8 Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

* Length of residence in city or town where death occurred 15 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

H.C. Rings

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 1, 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>44</u>	<u>9</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) Bancroft
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER P.H. Reed

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

12. MAIDEN NAME OF MOTHER Sarah E. Honn

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

14. INFORMANT H.C. Rings
(Address) 6217 Rock Hill Rd.

15. FILED 5/19/30 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19, 1930

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to May 18, 1930 that I last saw h. or alive on May 18, 1930, and that death occurred, on the date stated above, at 5:20 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A

(duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(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? no

WHAT TEST CONFIRMED DIAGNOSIS? microscopic

(Signed) George O. Bee M. D.
519, 1930 (Address) 1002 E. 4th St. P.M.O.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Holton, Kansas DATE OF BURIAL 5/19/30

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

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.

Dr. J. O. S. [unclear]
100 [unclear] [unclear]
[unclear] 24 [unclear]

11:30 to 2:30