

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

Do not use this space.

16270

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1007
 City Kansas City (No. Kansas City, Gen. Hosp.) St. _____ Ward)

File No. _____
 Registered No. 2109

2. FULL NAME

Rose Hunt
 (a) Residence. No. 44 3/4 Washington 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 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wm. Henry Post</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb. 1, 1891</u>				
7. AGE	YEARS <u>39</u>	MONTHS <u>3</u>	DAYS <u>20</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>housewife</u> (c) Name of employer				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-21 1930
 17. 4-28 I HEREBY CERTIFY, That I attended deceased from 5-21 1930
 that I last saw her alive on 5-21, 1930 and that death occurred, on the date stated above, at 3:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Small Intestine
460 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 45 (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Joseph Cook
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Permantown (STATE OR COUNTRY) Mo.
 12. MAIDEN NAME OF MOTHER Dresa Gable
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Permantown (STATE OR COUNTRY) Mo

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Gen. Path. Find.
 (Signed) P. C. Williams M. D.
5-21, 1930 (Address) Sup't. K.C. Gen. Hosp.

14. INFORMANT Reward Clerk
 (Address) K.C. Gen. Hosp.
 15. FILED 5/22, 30 M. M. Brown REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL W. Rose, Mo. DATE OF BURIAL 5-22 1930
 20. UNDERTAKER Mrs. C. L. Foster 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 PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

