

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. Research Hosp)

Registration District No. 399
Primary Registration District No. 1073

File No. _____
Registered No. 2219
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 3424 Smart 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 wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 9, 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 6 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Office Girl
(b) General nature of industry, business, or establishment in which employed (or employer). Stiles Rental
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

10. NAME OF FATHER

Carl J Hendrix

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

Agnes Love

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

14. INFORMANT

(Address) Carl J Hendrix
3424 Smart

15. FILED

5/26/30 M. M. Cowen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1930

17. I HEREBY CERTIFY, That I attended deceased from May 23 1930 to May 25 1930 that I last saw her alive on May 25 1930, and that death occurred, on the date stated above, at 2:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

CONTRIBUTORY (SECONDARY)

B2A-14A1 (duration) yrs. mos. 4 ds.
(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 Clinical Indings
(Signed) Frank H. Beach M. D.

May 16, 1930 (Address) Bozangyle 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

Memorial Rk

DATE OF BURIAL

5/28 1930

20. UNDERTAKER

S. H. Newcomes' Sons & Co

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

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