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.

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

Do not use this space.

16344

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 2252

Township Kaw — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. Kansas City Gen'l Hosp. St. Ward)

2. FULL NAME Rachel Dellinger

(a) Residence. No. No. 1023 1/2 W. 17th St., 4 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Wm. F. Dellinger

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 15 1871

7. AGE: YEARS 58 — MONTHS 6 — DAYS 12 — If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Lee Jacobs
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Sarah Samples
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Record Clerk
(Address) Kansas City Gen. Hosp.

15. FILED 5/28, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-27 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-27, 1930 to 5-27, 1930 that I last saw her alive on 5-27, 1930 and that death occurred, on the date stated above, at 7:35 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic cerebro spinal meningitis
18 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) 24 (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? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clin'l Lab Find + Autopsy
(Signed) P. E. Williams, M. D.
5-28, 1930 (Address) Gen Hosp. K.C. Mo.

*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: May 29 1930 (1 pm)

20. UNDERTAKER: Mrs. C. L. Forster — ADDRESS: K.C. Mo.