

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

Do not use this space.

19353

1. PLACE OF DEATH

County JACKSON
Township Kaw
City Kansas City Mo (No. MERCY HOSPITAL)

Registration District No. 399

Primary Registration District No. 1002

File No. _____
Registered No. 2338
St. _____ Ward _____

2. FULL NAME Anna Mae Harris

(a) Residence. No. 2011 S Boeke St., _____ Ward. Kansas City, Mo
(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 Fi. 4. COLOR OR RACE W 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) 5-23-30

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrq. ormin. 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kc. Kas.
(STATE OR COUNTRY)

10. NAME OF FATHER Bee L Harris

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

12. MAIDEN NAME OF MOTHER Edna Mae

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

14. INFORMANT Bee L Harris
(Address) 2011 S Boeke

15. FILED 6/3 1930 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3 1930

17. I HEREBY CERTIFY, that I attended deceased from 5-2, 1930, to 6-3, 1930, that I last saw h. alive on 6-3, 1930, and that death occurred, on the date stated above, at 7:24 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity

159
161A (duration) yrs. mos. ds.

CONTRIBUTORY Cong. atelectasis
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? At home
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical + physical
(Signed) S. Parkula M.D. M. D.

6/3 1930 (Address) Mercy Hospital.

*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 June 4 1930

20. UNDERTAKER Rose E Henderson ADDRESS City

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.

