

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

Do not use this space.

19403

1. PLACE OF DEATH

County Jackson
Township Kaw
City K.C. Mo

Registration District No. 399
Primary Registration District No. 1002
(No. Mercy Hospital)

File No. 2396
Registered No. _____
St. _____ Ward)

2. FULL NAME

Martha Chambers
(a) Residence. No. 736 Park Ave, Ward. _____
(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 F 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) 7-28-29

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
10 00

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chies 87
(b) General nature of industry, business, or establishment in which employed (or employer) 87
(c) Name of employer _____

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

10. NAME OF FATHER RUFUS Chambers

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

12. MAIDEN NAME OF MOTHER Lucy Klopferstine

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

14. INFORMANT Rufus Chambers
(Address) 511 park

15. FILED 6/8 1930 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-8-30 19

17. I HEREBY CERTIFY, That I attended deceased from 5-14-30 19, to 6-7 19, that I last saw her alive on 6-7 19, and that death occurred, on the date stated above, at 10:30 m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Medulla + Mastoiditis, bilateral
Submaxillary Abscesses, purulent
(duration) yrs. 3 mos. ds.
CONTRIBUTORY Septicemia, to above
(SECONDARY) (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy + clinical
(Signed) J. Pabula, M.D., M. D.

6/8, 1930 (Address) Mercy Hosp

*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 6/10 1930

20. UNDERTAKER Mrs C L Forster ADDRESS KC 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.

