

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

Do not use this space.

19478

**1. PLACE OF DEATH**

County Jackson  
Township Law  
City K. B. 4th

Registration District No. 399

Primary Registration District No. 3026-5-201002

File No. 2573  
Registered No. 2573  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 3026-6-20 St. 11 Ward \_\_\_\_\_

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 Female 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) June 9 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
3

**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) K. B. Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Leat Taylor

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

12. MAIDEN NAME OF MOTHER Flora McDonald

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

14. INFORMANT Leat Taylor  
(Address) 3026-6-20

15. FILED 6/13 1930 M. M. Crowe REGISTRAR  
Assn

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12 1930

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 12, 1930 that I last saw her alive on June 11, 1930, and that death occurred, on the date stated above, at 5 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Premature Birth

157  
158 (duration) yrs. mos. ds.  
CONTRIBUTORY Transient (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) W. M. Bauer, M. D.  
June 12, 1930 (Address) 2400 G. St.

\*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 12, 1930  
20. UNDERTAKER Rose & Henderson ADDRESS 15 Jackson

WHITE PLAINLY WITH UNFADING INK---THIS IS A PERMAMENT 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.

