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

Do not use this space.

23077

File No. .....

Registered No. 3071

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH
County Jackson
Township Kansas
City Kansas City (No. 5400 Woodland St. Ward)

2. FULL NAME Mary E. Tinsley

(a) Residence. No. 5400 Woodland St. Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Wh	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8-1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	72	1	15	

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

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

PARENTS

10. NAME OF FATHER John Moore

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

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) no record
(STATE OR COUNTRY)

14. INFORMANT Mallie Patterson
(Address) 5400 Woodland

15. FILED 7/25 30 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1930 to 7-23, 1930, to ....., 19.....
that I last saw her alive on 7-23, 1930 and that death occurred, on the date stated above, at 11. 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brights Disease
132 A
(duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) 2 yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH from gradual Decline of age
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis + Symptoms
(Signed) Leroy E. B. Sonn, M. D.
7/25 1930 (Address)

*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 July 26 1930

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

c/o Mrs. E. Crab Weiss
7626 Brooklyn -
Tel. [illegible] - Lind 4815