

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

Do not use this space.

26668

File No. _____
Registered No. 5272
St. _____ Ward)

1. PLACE OF DEATH

County Jackson Registration District No. 309
Township Ray Primary Registration District No. 1
City K.C. Mo (No. General Hospital #2)

2. FULL NAME

(a) Residence. No. 2209 Pine St., 4 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk. 1862
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 - - -
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundry work
(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) Mo

PARENTS

10. NAME OF FATHER Vernon David
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) VA
12. MAIDEN NAME OF MOTHER Faylor Hanna
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) VA

14. INFORMANT (Address) Residing clerk K.C. Genl Hosp #2
15. FILED 8/8 30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 5 - 1930
17. I HEREBY CERTIFY, That I attended deceased Aug 4, 1930 to Aug 5, 1930 that I last saw her alive on Aug 4, 3:40, 1930, and that death occurred, on the date stated above, at 3:40 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute myocarditis
Chronic Hypertension
Cardial Decumulation
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1290

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) A. Smith M. D.
K. 1930 (Address) General Hospital #2

*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 Highland Cemetery DATE OF BURIAL Aug 9 1930
ADDRESS West, L. P. Linton Jones 1600 E. 1907

20. UNDERTAKER West, L. P. Linton Jones

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.

