

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

Do not use this space.

26746

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 2010 E 16th)

Registration District No. 399
Primary Registration District No. 2002

File No. _____
Registered No. 3351
St. _____ Ward)

2. FULL NAME

Bessie Hughes
(a) Residence. No. 2010 E 16th St. 2 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
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 Fe 4. COLOR OR RACE Col. 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) unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>alt</u>	<u>38</u>			

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

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

10. NAME OF FATHER Peter Hughes

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

12. MAIDEN NAME OF MOTHER Jennie

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

14. INFORMANT Frances Smith
(Address) 2010 E 16th

15. FILED 9/12/30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/8 1930

17. I HEREBY CERTIFY, That I attended deceased from 8/4 1930,
that I last saw h. u alive on Aug 7th 1930, and that death occurred, on the date stated above, at 6a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

97A
97B Metical resurgitation
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) acute dilatation of heart
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH: _____

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

WHAT TEST CONFIRMED DIAGNOSIS Symptoms
(Signed) H. D. Jelovitz M. D.
8/11 19 30 Address 1729 Lydia

*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 Hestlawn DATE OF BURIAL 8/13 1930

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

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.

WRITE PLAINLY, WITH INK

Jersowitz.