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

Do not use this space.

26805

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 3410

Township Kaw — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. K.C. Gen'l Hosp. St. Ward)

2. FULL NAME Axie Shipman

(a) Residence. No. 3401 Garner St., 9 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 3 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)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 17, 1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	43	6	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Va.

PARENTS

10. NAME OF FATHER Wm. Martz

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

12. MAIDEN NAME OF MOTHER Eleanor Moyer

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

14. INFORMANT Ward Clerk
(Address) K.C. Gen. Hosp.

15. FILED 8/17 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 8-11, 1930, to 8-16, 1930 that I last saw her alive on 8-16, 1930 and that death occurred, on the date stated above, at 1:20 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Glioma of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

8-16 (Signed) P E Williams, M. D.

, 1930 (Address) Supt K.C. Gen. 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	DATE OF BURIAL
Maple Hill Cemetery	August 18 1930
20. UNDERTAKER	ADDRESS
John J. Sheehan	K.C. Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3410

City K. City (No. ....., ... St. ..... Ward)

2. FULL NAME Axie Shipman

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of 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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 8/17, 19 30 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Trauma of Brain
(malignant)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

49

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRAR ... FEE FOR CERTIFICATES UNTIL THEY ARE ... PR.

5-26805