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

Do not use this space.

30169

File No. 3977

Registered No.

1. PLACE OF DEATH

County Jackson. Registration District No.

Township Kaw Primary Registration District No.

City Kansas City, Mo (No. Mercy Hosp. St. Ward)

2. FULL NAME Bonnie Jean ~~[illegible]~~ Green

(a) Residence. No. 504 W. 18 St., 2 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 8 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.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 22. 1930

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	5	8	

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) Infant.
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Ralph

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

12. MAIDEN NAME OF MOTHER Leona Haas

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

14. INFORMANT Ralph Green
(Address) 504-W-18 th. St.

15. FILED 9/30, 19 M. M. Crowe REGISTRAR
Asst

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 30 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28 1930, 19..., to Sept 30, 1930 that I last saw her alive on Sept. 29, 1930 and that death occurred, on the date stated above, at 8 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Intestional Obstruction (Intussusception)

118 B1 (duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (SECONDARY) Toxemia from protein Absorption (duration) ...yrs. ...mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Sept. 29, 1930
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Operation, Clinical, Autopsy
(Signed) Sidney Parker, M.D.
Sept 30, 1930 (Address) Mercy Hospital

*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	Oct-2 1930

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