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

Do not use this space.

30190

1. PLACE OF DEATH
County Jackson
Township
City Leeds
Registration District No. 399
Primary Registration District No. 1002
(No. T. B. Hospital St. Ward)
File No.
Registered No. 3999

2. FULL NAME Virginia Lieu Stevens
(a) Residence. No. 1621 Oak St. St., 3 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 18, 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
70	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): Missouri

PARENTS
10. NAME OF FATHER: James Ogden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee
12. MAIDEN NAME OF MOTHER: Pauline Williamson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee

14. INFORMANT: T. B. Hospital
(Address) Leeds Sta. Kansas City Mo

15. FILED 10/1, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 3/24/30, 19.., to 9/30/30, 19.., that I last saw her alive on Sept 30, 1930, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Pulmonary
2319
(duration) over one year yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH unknown
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? X Ray & Laboratory
(Signed) Walter A. German, M. D.
Oct. 1, 1930 (Address) 733 Rialto Bldg K. C. Mo

*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: Elmwood
DATE OF BURIAL: Oct 1 1930

20. UNDERTAKER: Mrs. O. L. Forster
ADDRESS: K. C. Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PARENTS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.