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

Do not use this space.

31553

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. ..... 9167.

Township ..... Primary Registration District No. ..... Registered No. .....

City ..... (No. Missouri Baptist Hospital St. ..... Ward)

2. FULL NAME Georgia Sample

(a) Residence. No. 5525 Enright St., 5 Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	white	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 2 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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) Tenn. 9

PARENTS

10. NAME OF FATHER Philip McClanahan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Sipha Walker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT Nellie Sample
(Address) 5525 Enright av.

15. FILED 23, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

13

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-22-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-10-, 1930, to 9-22-, 1930 that I last saw her alive on 9-22-, 1930 and that death occurred, on the date stated above, at 7 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

9 Angina Pectoris
9 LA
94A
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chortic Regurgitation
Myocarditis Chronic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Not
DID AN OPERATION PRECEDE DEATH? DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Fundus
(Signed) R K Andrews, M. D.
9-22, 1930 (Address) Wall Bldg

*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
Kansas City Mo.	Sept 24 1930

20. UNDERTAKER	ADDRESS
Philander Craig	W4468 Washington

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.