

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.

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

32929

Do not use this space.

1. PLACE OF DEATH

County JacksonRegistration District No. 399Township KearPrimary Registration District No. 109City Kansas City, Mo.St. St. Andrews HospitalFile No. 4157Registered No. 4157

Ward)

2. FULL NAME

(a) Residence. No. 5102 Thompson 10 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

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

Dec 1856

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

73107

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)

Ind.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT.

(Address)

Guy Dawson
5102 Thompson

15.

FILED

10/13, 1930M. M. Grove

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

10-11-30

17.

HEREBY CERTIFY, That I attended deceased from

Sept 29, 1930, to Oct 11, 1930that I last saw him alive on Oct 11, 1930 and thatdeath occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia12:30 p.m.
10/11/30

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Operation to clear umbilical
hemorrhage

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 9/29/30WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.(Signed) M. M. Grove

M. D.

10/12, 1930 (Address) 1303 Walden 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

Cremation10/13 1930

20. UNDERTAKER

ADDRESS

O. Mast1915 E. 13

