

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

Do not use this space.

**32953**

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

Township Raw

Primary Registration District No. 1002

City K.C. Mo.

(No. Mercy Hospital)

File No. 4191  
Registered No. 4191  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2312 E. 12th St. St. 9 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 Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 29 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
6 20

**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) ✓  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Geo. F. Cox

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

12. MAIDEN NAME OF MOTHER Martha C. Cox

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

14. INFORMANT Geo. F. Cox  
(Address) 2312 E. 12th St.

15. FILED 6/15/30 19 30 Mo. REGISTRAR W.S.R.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/14/30 19

17. I HEREBY CERTIFY, That I attended deceased from 10/14/30, 1930 to 10/14/30, 1930 that I last saw her alive on 10/14/30, 1930, and that death occurred, on the date stated above, at 5:15 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

3  
Pr. Purulent St. Media  
49H  
89H  
1.88  
CONTRIBUTORY (SECONDARY) Pr. mastoiditis (duration) 2 yrs. 13 mos. 13 ds.  
Dehydration (?) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED at home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? yes  
WHAT TEST CONFIRMED DIAGNOSIS? Exam. Lab. autopsy

(Signed) Wm. Howard M. D.  
10/14/30 (Address) Mercy 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 Forest Hill DATE OF BURIAL 10-16-19 30

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

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

