

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

Do not use this space.

32993
4223

1. PLACE OF DEATH

County Jackson Registration District No. 395
Township Wau Primary Registration District No. 1002
City Sangas City Dist. Hosp. # 2. St. _____ Ward _____

2. FULL NAME

(a) Residence No. Upland Carey St. 4 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 Fe. 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-16, 1900.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
29 11 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER William Carey

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

12. MAIDEN NAME OF MOTHER Dora Williams

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

14. INFORMANT Dora White
(Address) 1917 E. 17th St.

15. FILED 10-18-30 WMM Chow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-15-30

17. Deputy Coroner
I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____.

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Metrial Regurgitation
124B
92H (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hypertrophic Cardiac
of the (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1012 W 151

19. DID AN OPERATION PRECEDE DEATH? _____ DATE _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Deputy Coroner
(Address) 1529

*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 Highland Cem. DATE OF BURIAL 10/18 1930.

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

WRITE PINNACLY, 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.

