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

Do not use this space.

39490

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City
Registration District No. 3 [illegible]
Primary Registration District No. [illegible]
(No. Vinyard Park Hospital St. Ward)
File No. [illegible]
Registered No. [illegible]

2. FULL NAME Mrs. Martha Viola Alexander
(a) Residence. No. 1403 Troost Ave. St., 2 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: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Hollis Alexander

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 22, 1883

7. AGE: Years 47; Months # 5; Days 24; If LESS than 1 day, ...hrs. or ....min.

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): Missuri

PARENTS
10. NAME OF FATHER: Wm. Pettit
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Anna Crocket
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: Hollis Alexander
(Address) 1403 Troost Ave.

15. FILED 12/17, 1930 M. M. Crowe REGISTRAR
Asst

6

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1930, to Dec 16, 1930 that I last saw her alive on Dec 16, 1930 and that death occurred, on the date stated above, at 12-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
54A Uremia (acute uriary
54B suppression)
133C
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Uterine Myoma, bilateral ovarian teratoma, chr. myocarditis
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
1 DID AN OPERATION PRECEDE DEATH? DATE OF Dec. 13-30
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J E Sheldon, M. D.
12-16, 1930. (Address) Box Corner 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: St. Joseph, Mo
DATE OF BURIAL: 12-18-30 19

20. UNDERTAKER: Fleeman Funeral Home, St, Joseph, Mo.
ADDRESS

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.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 3062

City Kansas City (No. ....., ... St. ..... Ward)

2. FULL NAME Martha Viola Alexander

(a) Residence. No..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	M

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

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

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1/17 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/16 1930

17. 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:
Uremia - acute urinary suppression
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Uterine myoma, Bilateral ovarian teratoma
..... (duration) ..... yrs. ..... mos. ..... ds.
Chr. myocarditis

18. WHERE WAS DISEASE CONTRACTED Non-malignant
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D.
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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