

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

Do not use this space.

39514

1. PLACE OF DEATH

County Jackson Registration District No. 388
Township Raw Primary Registration District No. 15
City Kansas City (No. 1301, East 5th)

File No. _____
Registered No. 5187
St. 14 Ward _____

2. FULL NAME Hattie May Rivers

(a) Residence. No. 1301 East 5th St., 14 Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 21-1903</u>		
7. AGE YEARS <u>27</u>	MONTHS <u>10</u>	DAYS <u>24</u>
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u> (c) Name of employer		

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15-1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1930 to Dec 15, 1930 that I last saw her alive on Dec 13, 1930 and that death occurred, on the date stated above, at 6-45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Tubercular meningitis
tuberculosis
23A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. ds.

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

10. NAME OF FATHER Cornelius Herring

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

12. MAIDEN NAME OF MOTHER Carrie Lemer

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

21. WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) [Signature] M. D.
12/17, 1930 (Address) 1572 N. 5th

14. INFORMANT Carrie Herring
(Address) 811 Cornell ave N.E. Kan

15. FILED 12/18 30 M. M. G. Miller REGISTRAR
[Signature]

*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 Westlawn DATE OF BURIAL 12-18 1930

20. UNDERTAKER H. C. Amb & Sacket Co ADDRESS 450 State ave N.E. Kansas

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

