

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

Do not use this space.

39715

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Kansas City Primary Registration District No. 1007 File No. 372  
 City Kansas City (No. General Hospital #2 St. 2 Registered No. 5291 Ward)

2. FULL NAME Mrs. Lively  
 (a) Residence. No. 2107 Howard St., \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*wife* the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6, 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>50</u>	<u>2</u>	<u>25</u>		

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) Miss

10. NAME OF FATHER Joe Lively

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Miss. ~~Miss.~~

12. MAIDEN NAME OF MOTHER Kathy Jordan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Miss.

14. INFORMANT Wm C Brown  
 (Address) 2107 Howard Ave

15. FILED 12/31 19 30 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-31-30  
 17. I HEREBY CERTIFY, That I attended deceased from 12-16, 1930 to 12-31, 1930 that I last saw ~~him~~ her alive on 12-31, 1930, and that death occurred, on the date stated above, at 9:45 p m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Carcinoma of Liver  
Male (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Leukemia (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? 411 B?  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Leukemia  
 (Signed) D. M. Miller M. D.  
731 1930 (Address) General Hosp. #2

\*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 Milligan, La DATE OF BURIAL Jan 5, 1931  
 20. UNDERTAKER Adkins Bros ADDRESS 2000 E-12th

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.

