

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

Do not use this space.

1271

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Haw Primary Registration District No. \_\_\_\_\_  
City Kansas City (No. St. Marys' Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 102

**2. FULL NAME** Hrs. Mary C. Bone Courtade

(a) Residence. No. 1414 Locust 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 <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles Courtade</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 21 1891</u>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
	<u>33</u>	<u>6</u>	<u>18</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>At Home</u>					
(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) Missouri

10. NAME OF FATHER William Bone

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

12. MAIDEN NAME OF MOTHER Mary Donnelly

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

14. INFORMANT Charles Courtade  
(Address) 1414 Locust

15. FILED Jan 9 1931 M. M. Browe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1931 1931  
17. I HEREBY CERTIFY, That I attended deceased from 1-4 1931 to 1-9 1931, and that I last saw her alive on 1-8-31, 1931, and that death occurred, on the date stated above, at 1:40 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Hypertension  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) A. H. Owens M. D.

17 1931 (Address) 1034 Rialto

\*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. Marys' Cemetery DATE OF BURIAL 1/12/31 1931

20. UNDERTAKER Quirk & Tobin--20 W. Linwood 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.

WHITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

