

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

Do not use this space.

1290  
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**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Kau Primary Registration District No. 1002  
City Kansas City, Mo. (Nearest Hospital) West Hospital

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Monroe, Cynthia  
(a) Residence. No. 2543 Woodland 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) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work laundress 10  
(b) General nature of industry, business, or establishment in which employed (or employer) n  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Plattsburg  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Gant, Geo

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Anna Stokes  
(Address) 1517 E. 21st

15. FILED 1-10-31 m m crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-7 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-1-31 19\_\_\_\_ to 1-7-31 19\_\_\_\_ that I last saw h. u. alive on 1-7-31 19\_\_\_\_, and that death occurred, on the date stated above, at 11:30 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Senility  
Pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Toxemia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) J. M. Miller M. D.

(Address) 17.15 m Gen 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 Blue Ridge Lawn DATE OF BURIAL 1-10 1931

20. UNDERTAKER J. W. Fisher ADDRESS 1217 Vassar

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.

