

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

Do not use this space.

5858

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City K.C. Mo.

Registration District No. 339  
Primary Registration District No. 74  
(Name) Mercy Hospital

File No. 952  
Registered No. 952  
St.        Ward       

**2. FULL NAME**

(a) Residence. No. 8714 Smart St., Ward Indep. Mo.  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1, 1916

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
14 9 26

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work School girl 11213/108  
(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) Mo.

10. NAME OF FATHER Martin Blakesley

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

12. MAIDEN NAME OF MOTHER Georgia Lane

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

14. INFORMANT Martin Blakesley  
(Address) 8714 Smart Ave. K.C. Mo.

15. FILED 2/27/31 M. M. Crowe REGISTRAR  
Ass.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27/31 19 31

17. I HEREBY CERTIFY, That I attended deceased from 2/23/31, 1931, to 2/27/31, 1931, that I last saw h. a. alive on 2/27/31, 1931, and that death occurred, on the date stated above, at 5:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Lt Lobar pneumonia

17 (duration) yrs. mos. da.  
CONTRIBUTORY Lt Pleurisy  
(SECONDARY) (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF       

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? exam - lab  
(Signed) W. H. Howard, M. D.  
2/27, 19 31 (Address) Mercy Hosp.

\*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 Mt. Washington DATE OF BURIAL Mar 1 1931

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

K. R.—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.

$$\begin{array}{r} 10 \\ 10 \\ \underline{6} \\ 5 \\ \hline 31 \end{array}$$