

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

Do not use this space.

17893

2028

1. PLACE OF DEATH

County Jackson
Township Ray
City Kansas City (No. 3805)

Registration District No. 399
Sanitary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Mrs. Elizabeth Prior
(a) Residence. No. 3805 Florida Ward. 13
(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

3. SEX Female 4. COLOR OR RACE White 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) Aug 29 - 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>56</u>	<u>8</u>	<u>31</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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 Dwight Hanes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) 187

12. MAIDEN NAME OF MOTHER Mary Keenan

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

14. INFORMANT Mrs. J. J. Fobbe
(Address) 3805 Florida

15. FILED 5-2-31 1931
REGISTRAR Wm. J. Timm

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1931

17. I HEREBY CERTIFY, That I attended deceased from 11:19, 1931, to 5:12, 1931, that I last saw her alive on 5:12, 1931; and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

71A Pneumonia
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Don't know
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 71A
IF NOT AT PLACE OF DEATH... (1)

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptom
(Signed) H. S. Denton, M. D.

*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. St. Mary Cem DATE OF BURIAL 5/14 1931

20. UNDERTAKER J. S. Dorell ADDRESS 3256 Broadway

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. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

