

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

Do not use this space.

24961

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 100
 City J.P. Mo. (No. St. Lukes Hospital St. _____ Ward _____)

File No. _____
 Registered No. 2034

2. FULL NAME

Ada Mapes
 (a) Residence. No. 7115 Summit St. 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. B. Mapes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 07-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 5 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife
 (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) Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

14. INFORMANT

Mrs. B. Mapes
 (Address) 7115 Summit

15. DATE

July 31 1931 M. M. Cronin
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4, 1931

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1931, to July 4, 1931, that I last saw her alive on July 4, 1931, and that death occurred, on the date stated above, at 10:43 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure due to Coroner's fibrillation

133A
95A (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Chronic Pericarditis (duration) yrs. mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH 7115 Summit

DID AN OPERATION PRECEDE DEATH? yes DATE OF June 22 '31

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Blind attendance

(Signed) [Signature] M. D.

7-6-1931 (Address)

*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 Forest Hill DATE OF BURIAL 7-6-1931

20. UNDERTAKER Mrs. C. L. Foster ADDRESS N. E. Mo.

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.

923W33No-707

72-7134

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