

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

Do not use this space.

1. PLACE OF DEATH

County..... Jackson Registration District No. 399 File No. 28253
 Township..... Ray Primary Registration District No. 1002 Registered No. 3351
 City..... Kansas City, Mo. (No. 4113 Tracy) St. 3351 Ward

2. FULL NAME

(a) Residence. No. 4113 Tracy St. 11 Ward. 1002
 (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 Female 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 David S. Confer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12 - 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 | 1 | 25 | — | — | —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Franklin Co. Penn
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Daniel A. Miller

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

12. MAIDEN NAME OF MOTHER Amelia Washbaugh

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

14. INFORMANT David S. Confer
 (Address) 4113 Tracy

15. FILED 8/7 3 1931 M.M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

Friday

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

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1931, to August 7, 1931, that I last saw h. alive on Aug 7, 1931, and that death occurred, on the date stated above, at 6:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Paresthesia
Embryonic Hemorrhage
748

CONTRIBUTORY (SECONDARY) Septic
 (duration) 6 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED Home

IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

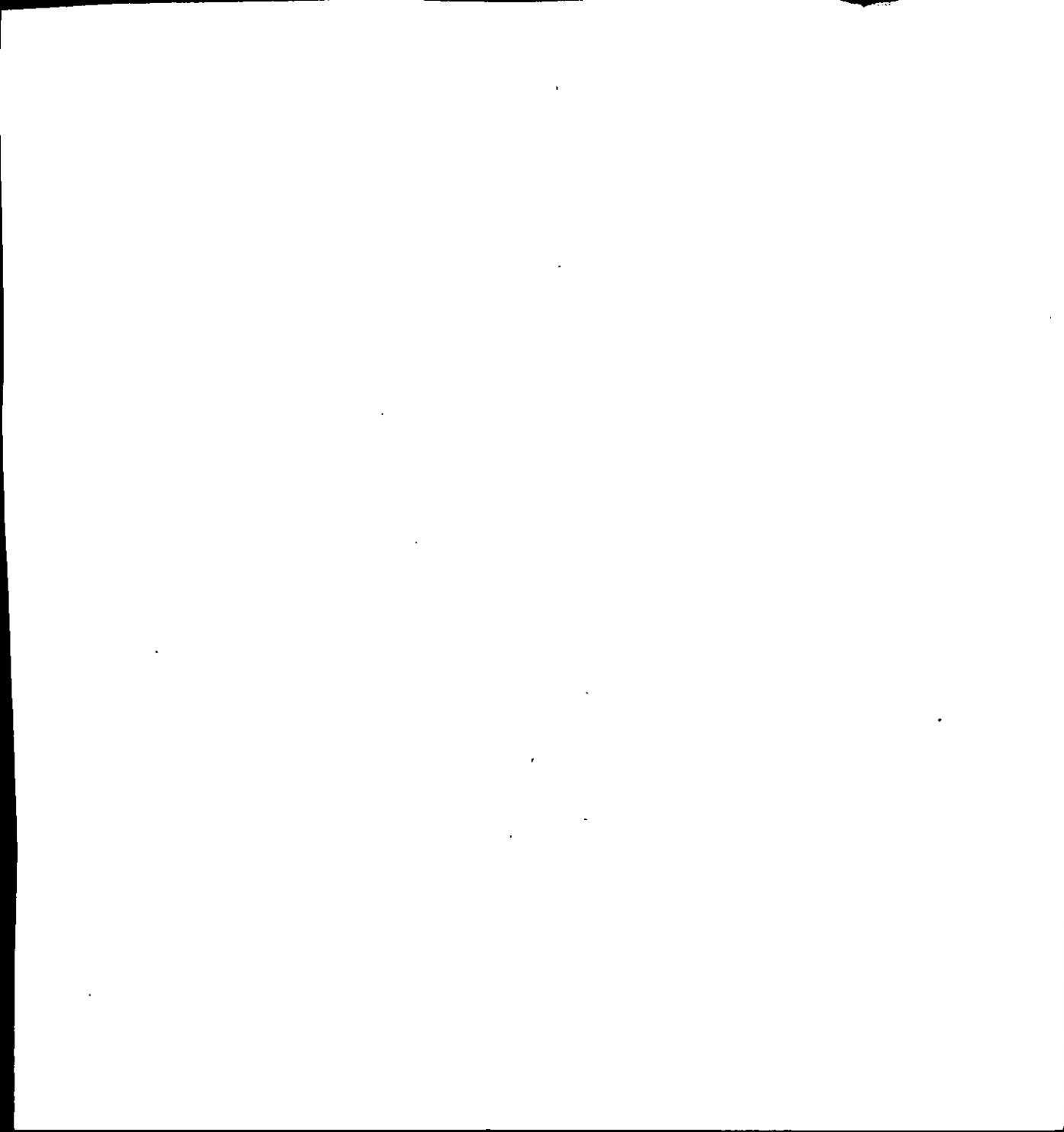
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) D. H. Kelly M. D.
7, 1931 (Address) 610 Broadway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Altoona Pa DATE OF BURIAL Aug 9 1931

20. UNDERTAKER Eylar Funeral Home ADDRESS 1802 Lincoln



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 3380
 City X City (No.) St. Ward

2. FULL NAME

Mrs. Ida Florence Cooper

(a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 64 X 1 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.
 (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).....

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT (Address).....

15. FILED 8/7 31 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. 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)....., M. D. , 19 (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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-58253