

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

Do not use this space.

31430

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. St Marys Hospital St. _____ Ward)

Registration District No. 399

Primary Registration District No. 1007

File No. _____
Registered No. 3928

2. FULL NAME

Irene Blackentith
(a) Residence. No. Marceline Missouri Ward. _____

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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about 26</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) No longer in Mo
(STATE OR COUNTRY) _____

10. NAME OF FATHER John Blackentith

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

12. MAIDEN NAME OF MOTHER Nellie McGuire

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

14. INFORMANT Mrs Rose Homan
(Address) 2820 Harrison 11C Mo

15. FILED 9/24/31 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 24 1931

17. I HEREBY CERTIFY, That I attended deceased from June 20 1931 to Sept 21 1931 that I last saw her alive on Sept 21 1931 and that death occurred, on the date stated above at 7:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:-

Rheumatic aortic endocarditis (chronic)
(duration) yrs. 6 mos. _____ ds. _____
CONTRIBUTORY (SECONDARY) chronic passive congested liver
(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? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) M. J. Jones M. D.

(Address) 104 Ferguson St. Mo

*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 Marceline Mo
Mt Killeard DATE OF BURIAL Sept 26 1931

20. UNDERTAKER Daniels Bros
ADDRESS 644 Kansas Ave KCK

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

1. 4015