

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

Do not use this space.

37675

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City, Mo.

Registration District No. 313  
Primary Registration District No. 1000  
St. Joseph Hospital # 2

File No. 4541  
Registered No. 4541  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 1512 1/2 Park St. 11 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 Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5 1912  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 19 10 16

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Maid  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

13. NAME Les Hughes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Hester W. W. W.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Hester W. W. W.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE Nov 15 1931

19. UNDERTAKER (ADDRESS) Shelton Funeral Home

20. FILED 11/12 1931 M. M. Crowe Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-11 1931

22. I HEREBY CERTIFY, That I attended deceased from 10-31 1931 to 11-11 1931  
I last saw him alive on 11-11 1931. Death is said to have occurred on the date stated above, at 5 P.M.

The principal cause of death and related causes of importance were as follows:

Acute Appendicitis  
Generalized Peritonitis  
Corysipelas  
Date of onset ?

Other contributory causes of importance  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify \_\_\_\_\_ (Signed) Dr. Miller, M. D.  
(Address) St. Joseph Hospital #2

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

