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

Do not use this space.

37955

File No. .....

Registered No. 221

1. PLACE OF DEATH

County Jackson Registration District No. 400

Township Prairie Primary Registration District No. 5553B

City Little Blue Mo. (No. Jackson County Home St. ..... Ward)

2. FULL NAME Mattie Thomas

(a) Residence. No. 516 Charlotte St., ... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 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: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Married

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

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

7. AGE: Years: About 65 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN): Unknown

(STATE OR COUNTRY): Kentucky

PARENTS

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown

(STATE OR COUNTRY): Kentucky

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown

(STATE OR COUNTRY): Kentucky

14. INFORMANT: County Home Records

(Address): Little Blue Mo.

15. FILED 11-21, 1931 William T. Fields

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 17 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1931, to Nov 17, 1931 that I last saw h. alive on Nov 17, 1931, and that death occurred, on the date stated above, at 10 O'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac - Renal

Mitral Insufficiency

Chronic Parenchymatous Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.

(Signed) J. W. Booker, M. D.

, 19 (Address) 2203 Vine

*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: K.C. College of Physicians & Surgeons

DATE OF BURIAL: 11-21-31

20. UNDERTAKER: Flynn & Greenstreet

ADDRESS: K.C. 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.

DEC 22 1931