

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

Do not use this space.

40863

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Kaw

Primary Registration District No. 1002D

City Kansas City

3014 William Rd

File No. 4882

Registered No. _____

St. _____ Ward _____

2. FULL NAME

Margaret Elizabeth King Van Horne

(a) Residence. No. 3014 William Rd, _____
(Usual place of abode) _____

Length of residence in city or town where death occurred 9 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 16 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
69 87 20

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) Ind

PARENTS

10. NAME OF FATHER Hiram King

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

12. MAIDEN NAME OF MOTHER Nancy E. Reed

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

14. INFORMANT Miss Margaret Van Horne

(Address) 3014 William Rd

15. FILED 12/5 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1931 to Dec 5 1931 that I last saw her alive on Dec 5 1931, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Pneumonia (Bronchial)

A 2 P (duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic (duration) 10 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? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings

(Signed) M. M. Crowe M. D.

, 19 (Address) 810 Rialto Bldg

*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 Lindsborg Kans DATE OF BURIAL 12-7 1931

20. UNDERTAKER Porter & Eads ADDRESS W. C.

WHITE PRINT, 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.

