

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

Do not use this space.

41040

5028

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kanawha Primary Registration District No. _____
 City Kansas City (No. Trinity Luth Hosp) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward Westline, Mo
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 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) Single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
16 3 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

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) Fourburg Kansas

13. NAME Lee York

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fourburg Kansas

15. MAIDEN NAME Martha Cook

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fourburg Kansas

17. INFORMANT (ADDRESS) Mrs. W. H. Brown Westline, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Fourburg, Mo. DATE 12-21-31

19. UNDERTAKER (ADDRESS) W. B. Ryan Fourburg, Mo.

20. FILED 12/19/31 10:20 am Registrar W. B. Ryan

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-19, 1931

22. I HEREBY CERTIFY, That I attended deceased from _____

Dec. 16, 1931, to Dec 19, 1931

I last saw her alive on Dec 19, 1931 Death is said

to have occurred on the date stated above, at 1:30 p.m.

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

Peritonitis following ruptured appendix Date of onset _____

Other contributory causes of importance: Generalized peritonitis

Name of operation Appendectomy Date of 12/17/31

What test confirmed diagnosis? Microscopic 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) Geo. B. Norberg, M. D.

(Address) 111 Arroyo City, Mo.

Registrar W. B. Ryan

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 UNFOLDING MATERIALS IN A PERMANENT RECORD

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399
 Township..... Primary Registration District No. 1002
 City K. City (No.) St. Ward)

2. FULL NAME Norma Mae York

(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 (write the word) M
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 27 1915
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
16 3 1 22

OCCUPATION
 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.
 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)

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 12/19 1931 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/19 1931

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify (Signed)....., M. D.
 (Address).....

SUPPLEMENTARY

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.

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

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

S-4104D .