

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

Do not use this space.

H 1248
File No. _____
Registered _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson
Township Prairie
City _____ (No. _____)

Registration District No. 400
Primary Registration District No. 5553B

2. FULL NAME

(a) Residence, No. Jackson County, Mo. Ward _____
(Usual place of abode)

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) widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1 - - - 1872

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>About</u>	<u>59</u>	<u>-</u>	<u>-</u>	

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

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) Ireland

13. NAME Widow

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

15. MAIDEN NAME _____

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

17. INFORMANT J. W. Foster
(ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE K.C. City Cem. Date 10 - 24 - 1931

19. UNDERTAKER Kettler
(ADDRESS) Beuss

20. FILED 12-22-31 1931 William Fields
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 12/19/31 to 12-19-1931

I last saw her alive on 12-17-1931. Death is said to have occurred on the date stated above, at 9 P. m.

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

chronic myocarditis Date of onset _____

Other contributory causes of importance: 931

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

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) J. W. Foster M. D.
(Address) Independence 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 every important.

1931

