

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

Do not use this space.

8536

1. PLACE OF DEATH

County Jackson
Township Yves
City Kansas City (No. K.C. General Hosp)

Registration District No. 399
Primary Registration District No. 1052

File No. _____
Registered No. 1118
St. _____ Ward _____

2. FULL NAME

Julia Black
(a) Residence, No. 224 N. Park St. 7 Ward.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 7 - 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>51</u>	<u>6</u>	<u>10</u>	

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 235

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) Ross County Mo

13. NAME John Spitzer

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

15. MAIDEN NAME Anna Ewing

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

17. INFORMANT (ADDRESS) Reuben Black K.C. Gen Hosp p. 72C Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St Joseph, Mo DATE 3-19-1932

19. UNDERTAKER (ADDRESS) Peter B. Kapitanis K.C. Mo

20. FILED 3/18 32 M. M. G. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-17 1932

22. I HEREBY CERTIFY, That I attended deceased from 3-12 1932 to 3-17 1932
I last saw her alive on 3-17 1932 Death is said to have occurred on the date stated above, at 9:40 a.m.

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

Pneumonia
Date of onset _____
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Other contributory causes of importance: (1)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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?
If so, specify _____

(Signed) P. B. Willard M. D.
(Address) Sub K.C. Gen Hosp K.C. Mo

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 OMPACTING INK—THIS IS A PERMANENT RECORD

