

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

Do not use this space.

8659

1. PLACE OF DEATH

County Jackson Registration District No. 389
 Township Jean Primary Registration District No. 9002
 City Kansas City (No. Kansas City Gen Hosp St. _____ Ward _____)

File No. _____
 Registered No. 1244

2. FULL NAME

Carrie Evers
 (a) Residence, No. 8 W. 16th St. 1 Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 1 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 Widow
 SA. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 16, 1849
 7. AGE YEARS 82 MONTHS 7 DAYS 0
 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
 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) mo 1

13. NAME Wm. R. Rucker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 31

15. MAIDEN NAME Mary Ann Priest

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

17. INFORMANT (ADDRESS) Revd. Clerk
R.C. Gen. Hosp. R.C.M.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul DATE 2-25 1932

19. UNDERTAKER (ADDRESS) 6 mg

20. FILED 3/25 1932 M. M. Corowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-16 1932

22. I HEREBY CERTIFY, That I attended deceased from 2-7 1932 to 3-16 1932
 I last saw her alive on 3-16 1932 Death is said to have occurred on the date stated above, at 10:00 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
936
162
930
 Other contributory causes of importance:
Semilunar
(1)

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) R. M. Matthews M. D.
 (Address) Sup. R.C. Gen. Hosp. R.C.M.
3-19-32

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.

