

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

Do not use this space.

19540

1. PLACE OF DEATH

County Jackson

Registration District No. 389

Township 1st

Primary Registration District No. 1002

City 1100 Base

File No. _____

Registered No. 2589

St. 2017 (Ward)

2. FULL NAME

(a) Residence. No. 1100 Base Ward. 2

(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 Female

4. COLOR OR RACE Cal

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 10th 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 10 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Command Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 237

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Gene Bluff Ark 20
(STATE OR COUNTRY)

10. NAME OF FATHER Louis Bulliver

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Gene Bluff Ark
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Phodasia Dawson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Gene Bluff Ark
(STATE OR COUNTRY)

14. INFORMANT Louis Bulliver
(Address) 1100 Base

15. FILED 6/13 32 M.M. Brown
REGISTRAR assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/10 1932

17. I HEREBY CERTIFY, That I attended deceased from about 5/16, 1932, to 6/10, 1932 that I last saw her alive on 6/7, 1932 and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

T.B. of the lungs
237

CONTRIBUTORY (SECONDARY) Exposure to infection
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Place of death

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) W. O. Taylor M. D.

6/11, 1932 (Address) 1705 E 77 St

*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 Highland DATE OF BURIAL 6/13 1932

20. UNDERTAKER Dwyer Bros. Funeral Home ADDRESS 1708 Tracy St. E. 6. 1701

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.

