

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

Do not use this space.

26258

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Precinct Registration District No. 100
City Kansas Cit. (No. 3540) St. Anthony

File No. _____
Registered No. 3166
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3540 Drury St., 14 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 38 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-6-1894
7. AGE YEARS 38 MONTHS 5 DAYS 76 If LESS than 1 day, _____ hrs. or _____ min.

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) Kansas City, Mo.

13. NAME William Clay

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe County, Mo.

15. MAIDEN NAME Sarah Scott

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

17. INFORMANT Record Clerk Gen. Hosp #2 (ADDRESS) _____

18. BURIAL, CREMATION OR REMOVAL PLACE Highland DATE Aug 18, 1932

19. UNDERTAKER (ADDRESS) Adkins Bros. 2008 E. 125th

20. FILED Aug 16, 1932 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-12 1932

22. I HEREBY CERTIFY, That I attended deceased from 7-30 1932, to 8-12 1932

I last saw her alive on 8-12 1932 Death is said to have occurred on the date stated above, at 9th m.

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

Carcinoma of Uterus Date of onset 48
Toxemia

Other contributory causes of importance:

Name of operation None 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. M. Miller, M. D.
(Address) Gen. Hosp #2

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.

