

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

Do not use this space.  
**32257 3784**

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Osaw Primary Registration District No. \_\_\_\_\_  
 City Kansas City (No. 7C General Hosp) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 445 Colorado Ward \_\_\_\_\_  
 (Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-7, 1932

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm M. Woods

22. I HEREBY CERTIFY, That I attended deceased from 10-6, 1932 to 10-7, 1932

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June-28-1889

I last saw her alive on 10-7, 1932 Death is said to have occurred on the date stated above, at 6:10 P.M.

7. AGE YEARS 43 MONTHS 3 DAYS 9 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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

Cerebral hemorrhage  
Generalized arteriosclerosis  
75-8  
83A  
75-13  
70-13

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none <sup>235</sup>

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Cardiac Hypertrophy

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME John Dreese

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

15. MAIDEN NAME not known

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

17. INFORMANT Beura Clark  
(ADDRESS) 7C Gen Hosp KCMO

18. BURIAL, CREMATION, OR REMOVAL PLACE McDonald, Illinois DATE Oct-8-1932

19. UNDERTAKER Mrs. C. L. Foster  
(ADDRESS) 918 Brooklyn ave

20. FILED 10/8, 1932 W. M. Ogden Registrar.

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) P. E. Williams M. D.

(Address) Supt K. C Gen Hosp KCMO

WRITE IN INK, 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.

