

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.

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

Do not use this space.

35699

1. PLACE OF DEATH

County Jackson Registration District No. 389
 Township Kaw Primary Registration District No. 2002
 City Kansas City (No. 706-E-71 St Terrace St. 4201 Ward)

2. FULL NAME

Margaret A. Moland
 (a) Residence, No. 706-E-71 St Terrace St. 4201 Ward.
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>	
		5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>January 10 - 1873</u>			
7. AGE	YEARS <u>59</u>	MONTHS <u>9</u>	DAYS <u>28</u>
	If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u>		
	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 <u>10</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Water Proof 2. Louisiana</u>			
FATHER	13. NAME <u>James J. Baine</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland 15</u>		
MOTHER	15. MAIDEN NAME <u>Bridget O'Brien</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>		
17. INFORMANT <u>Margaret A. Moland</u> (ADDRESS) <u>706 E 71 St Kansas City Mo</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oldway</u> DATE <u>11-10-32</u>			
19. UNDERTAKER <u>Sheehan</u> (ADDRESS) <u>Reims</u>			
20. FILED <u>Nov. 9 1932</u> <u>Wm. M. Lowrey</u> <u>Asst Registrar.</u>			

3 MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY That I attended deceased from July 7 1929, to Nov 8 1932.
 I last saw him alive on June 11 1932. Death is said to have occurred on the date stated above, at 5 A. m.
 The principal cause of death and related causes of importance were as follows:

<u>Cerebral hemorrhage</u>	Date of onset <u>11/8/32</u>
<u>Intense hypertension</u>	<u>1918</u>
<u>Auricular fibrillation</u>	<u>1918</u>

Other contributory causes of importance:
St. A. O.

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? No
 If so, specify _____
 (Signed) Raphaels _____, M. D.
 (Address) 914 Mac Arts

- Mr. Joseph H. Mayo
Medical arts Bldg
Phone Va 6947