

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.

5829

1. PLACE OF DEATH
 48 County Jackson Registration District No. 899
 16 Township New Primary Registration District No. 1001
 9 City Kansas City, Mo. No. General Hospital # 2 File No. 5
 Registered No. 781 St. _____ Ward _____

2. FULL NAME Lusie Layles
 (a) Residence, No. 2229 Harrison St. Ward _____
 (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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 23, 1864

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>68</u>	<u>8</u>	<u>20</u>	

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. None

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) Springfield, Ill.

FATHER

13. NAME Harriet Allen

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

MOTHER

15. MAIDEN NAME Martha Christian

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Feb. 16, 1933

19. UNDERTAKER (ADDRESS) Statins Bros. Und. Co., 21 Lydia

20. FILED 2-16-33 in M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/12 1933

22. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1933 to Feb. 12, 1933

I last saw her alive on Feb. 12, 1933 Death is said to have occurred on the date stated above, at 6:40 P.M.

The principal cause of death and related causes of importance were as follows:
Chronic Parenchymatous Nephritis
Chronic Myocarditis
Senile Dementia

Date of onset _____

Other contributory causes of importance: 131

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

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 _____
 (Signature) O. O. Spence Supl. M. D.
 (Address) General Hosp. # 2

