

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

Do not use this space.

13509

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Lew Primary Registration District No. 1001 File No. 1845
 City Kansas City (No. St. Marys Hospital) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 121 - 1st Ave. 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 Fe 4. COLOR OR RACE American 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. E. Craig

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-18-1882

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, or _____ min.
	50	5	8	

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kingsville Mo.

13. NAME Simpson Boone 3

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no.

15. MAIDEN NAME Visa Burnett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no.

17. INFORMANT St Marys Hosp.
 (ADDRESS) 121 - 1st Ave.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE St Marys DATE 4-28-33

19. UNDERTAKER Peter B. Sargent
 (ADDRESS) K. L. 2nd

20. FILED Apr 27, 1933 in M. M. Boone
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-26-33 19

22. I HEREBY CERTIFY, That I attended deceased from Sam 1932 to 4/26/33, 19
 I last saw he alive on 4/26/33, 19. Death is said to have occurred on the date stated above, at 9:30 P.M.

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

Carcinoma of Cervix Date of onset _____
Chronic pyelonephritis
40
133A Other contributory causes of importance: 48

Name of operation Radiation therapy Date of _____
 What test confirmed diagnosis urinary 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 directly related to occupation of deceased? _____
 If so, specify _____
 (Signed) [Signature], M. D.
 (Address) St Marys Hospital

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.

