

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township _____ Primary Registration District No. _____
City Kansas City (No. Lakeside Hospital)

File No. 16653
Registered No. 2149
St. _____ Ward _____

2. FULL NAME Maude Alice Skinner

(a) Residence. No. Rt. 1, K. C. K. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 36 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/11/1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>36</u>	<u>3</u>	<u>5</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) own home
(c) Name of employer self

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Isaac McClure

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nashville
(STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Amanda Katherman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lawrence
(STATE OR COUNTRY) Kan.

14. INFORMANT Harry Skinner
(Address) Rt. 1 KCK

15. FILED May 18, 1933 M. M. Brown REGISTRAR
Asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16th June 19 33

17. I HEREBY CERTIFY, That I attended deceased from May 8th, 1933, to May 16th, 1933, that I last saw h.s. alive on May 15th, 1933, and that death occurred, on the date stated above, at 9:17 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Parenchymatous Nephritis

CONTRIBUTORY (SECONDARY) Acute cholecystitis + gall stones
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 126
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation
(Signed) D. J. Graham
, 19 (Address) Lakeside Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland Park KCK DATE OF BURIAL 5/19 1933

20. UNDERTAKER Geo. H. Long Mortuary ADDRESS _____

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.

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