

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

Do not use this space.

29517

**1. PLACE OF DEATH**

County Jackson  
Township Independence  
City Independence No. \_\_\_\_\_

Registration District No. 398  
Primary Registration District No. 3019

File No. \_\_\_\_\_  
Registered No. 274 St. \_\_\_\_\_ Ward)

**2. FULL NAME**

J. Mary Jane Dale  
(a) Residence No. 807 W. Main St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 4 mos. \_\_\_\_\_ ds. \_\_\_\_\_

Albion Mo.  
(If nonresident, give city or town and State)

How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17, 1837

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>96</u>	<u>1</u>	<u>19</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

10. NAME OF FATHER James Hutchison

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Kate Rouse

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known  
(STATE OR COUNTRY)

14. INFORMANT Wm Dale  
(Address) Independence Mo

15. FILED Sept 3 1933 Dr. F. L. Cook  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1933

17. I HEREBY CERTIFY, That I attended deceased from August 28, 1933 to Sept 2, 1933 that I last saw her alive on Sept 2, 1933 and that death occurred, on the date stated above, at 7:05 P.M. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Senile myocarditis

79C  
16<sup>hr</sup> (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_  
CONTRIBUTORY Infarction of the heart  
(SECONDARY) (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chemical  
(Signed) W. Allen, M. D.

Sept 2, 1933 (Address) Queen - North End Independence Mo

\*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 Albion Mo DATE OF BURIAL Sept 4 1933

20. UNDERTAKER L. C. Harrison ADDRESS Albion

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.

WHITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

