

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

Do not use this space.

29664
3588
3588

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township 2nd Mo. Primary Registration District No. _____
City General Hospital #2 St. (No. _____) Registered No. 3rd Ward

2. FULL NAME

(a) Residence, No. 811 Charlotte St. Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 40 yrs. 10 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 Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 7 1863
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. (?) 70 0 1
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
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) Kansas

13. NAME Deceased

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) Record Dept. General Hosp. #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland Cem. DATE Sep 12, 1933

19. UNDERTAKER (ADDRESS) Edkins Bros. 2000 E. 12th

20. FILED 9-9-1933 an an an Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-8, 1933
22. I HEREBY CERTIFY, That I attended deceased from 8-2, 1933 to 9-8, 1933
I last saw her alive on 9-8, 1933 Death is said to have occurred on the date stated above, at 6:35 a.m.

The principal cause of death and related causes of importance were as follows:
Chronic Valvular Heart Disease
12A
107A
Other contributory causes of importance:
Broncho-Pneumonia (terminal)

8 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 _____
(Signed) J. O. Young M.D.
(Address) General Hospital #2

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

20 1933

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