

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

Do not use this space.

29931  
3857

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Kaw Primary Registration District No. \_\_\_\_\_  
City Leansbury (No. 12) General Hosp St. \_\_\_\_\_ Ward) \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 2731 Jackson 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. 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) Widow  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12 - 1872  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
61 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework  
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) Mo

13. NAME Byron Seward

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

15. MAIDEN NAME Elmira Bevens

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

17. INFORMANT Bevna Clark  
(ADDRESS) 122 Gen Hosp Rm

18. BURIAL, CREMATION, OR REMOVAL PLACE Cent. Wash DATE 10/2/33

19. UNDERTAKER Mrs. C. L. Foster  
(ADDRESS) 918 12 200th Ave

20. FILED 9-30 1933 m m Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-29 1933

22. I HEREBY CERTIFY, That I attended deceased from 9-23 1933 to 9-29 1933  
I last saw her alive on 9-29 1933 Death is said to have occurred on the date stated above, at 1:50 PM  
The principal cause of death and related causes of importance were as follows:

Cardio Pny disease Date of onset \_\_\_\_\_

Other contributory causes of importance: 95B 131

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) P. J. De Maria, M. D.  
(Address) Adm't Hosp K. C. Gen Hosp

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.

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