

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

Do not use this space.

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1. PLACE OF DEATH

County JACKSON

Township KAW

City KANSAS CITY

Registration District No. 898

Primary Registration District No. 7002

(No. 4643 TRACY

File No. _____

Registered No. 4270

St. _____ Ward _____

2. FULL NAME MRS BELLE

DAWSON

(a) Residence, No. 4643 TRACY

St. _____ Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 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 ARTHUR DAWSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 23 1870

7. AGE YEARS 63 MONTHS 4 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

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) MISSOURI

13. NAME SAMUEL OTT

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

15. MAIDEN NAME UNKNOWN

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

17. INFORMANT MR. ARTHUR DAWSON (ADDRESS) 4643 TRACY AVE

18. BURIAL, CREMATION, OR REMOVAL PLACE MT. HOPE - K.C. KANS. DATE OCTOBER 31 1933

19. UNDERTAKER D. W. NEWCOMER'S SONS (ADDRESS) KANSAS CITY, MISSOURI

20. FILED 10-31-33 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 1932 to Oct 29 1933

I last saw her alive on Oct 29 1933 Death is said

to have occurred on the date stated above, at 11:20 A.M.

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

Cardiac Exhaustion
Terminal Pneumonia
Starvation
Digestive Disturbance
Pyonephrosis
Transverse Myelitis

Name of operation Crowe Date of _____

What test confirmed diagnosis? Clinical 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? _____

If so, specify Isadore Anderson (Signed) _____, M. D.

(Address) 1317 Chialto Bldg

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

Mr. Isadore Anderson

1317 Rialto Bldg.

2:00- 3:25