

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

Do not use this space.

36656

1. PLACE OF DEATH

County Jackson Registration District No. _____

Township Kaw Primary Registration District No. _____

City Kansas City No. Kansas City General Hosp. (Ward)

File No. _____

Registered No. 4570

2. FULL NAME

(a) Residence, No. 2213 1/2 E 9th St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 7 1898

7. AGE YEARS 35 MONTHS _____ DAYS 14 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) Kansas

13. NAME John Walker

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Reena Clark (ADDRESS) 2213 1/2 E 9th St. KC, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buffalo Kans. DATE Nov. 22 1933

19. UNDERTAKER W. J. Mayberry (ADDRESS) Re. mo.

20. FILED Nov 22 1933 M. C. Croome Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-21 1933

22. I HEREBY CERTIFY, That I attended deceased from 11-19, 1933, to 11-21, 1933

I last saw her alive on 11-21, 1933 Death is said

to have occurred on the date stated above, at 9:20 P.M.

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

Cerebral Hemorrhage Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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. F. De Maria, M. D.

(Address) Ant. Dept. 740 Gen. Hosp.

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.

JAN 28 1934

WRITE PLAINLY, WITH CHANGING INITIALS IS A PERMANENT RECORD

