

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson

Registration District No. 388

File No. 16909

Township W.C. Mo.

Primary Registration District No. 2003

Registered No. 277

City General Hospital #21

(No. 3rd Ward)

**2. FULL NAME**

(a) Residence, No. 912 E. 16th St. 3rd Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-13-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70 0 7

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

FATHER 13. NAME Deceased

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

MOTHER 15. MAIDEN NAME Deceased

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Shalmond DATE 5/24

19. UNDERTAKER (ADDRESS) Watkins Bros

20. FILED May 23, 1934 M. M. Crowe asst Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20 1934

22. I HEREBY CERTIFY, That I attended deceased from 5-19 1934 to 5-20 1934

I last saw h. W alive on 5-20 1934 Death is said to have occurred on the date stated above, at 3:00 P.M.

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

Chronic Nephrosy  
131 Nephritis  
1323  
Other contributory causes of importance: Anemia

Name of operation Amputation Date of No  
What test confirmed diagnosis? Amputation 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  
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. Thomas M. D.  
(Address) General Hosp. #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.

JUN 19 1934

