

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

Do not use this space.

SEP 20 1934

29479

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 29479  
 Township Jay Primary Registration District No. 399 Registered No. 102  
 City J.C. Mo. (No. General Hosp. #2 St. 3rd Ward)

**2. FULL NAME**

(a) Residence, No. 605 Harrison St. Ward. \_\_\_\_\_ (If nonresident, give city or town and State)  
 (Usual place of abode)

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  
~~WIFE~~  
 (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-16-1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
52 11 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
 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) La.

13. NAME Ma West

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

15. MAIDEN NAME Nattie Wink

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

17. INFORMANT (ADDRESS) General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Deeds mo DATE 8-21 1934

19. UNDERTAKER (ADDRESS) AB Crook  
1820 E 18 St

20. FILED 9/20 1934 M. M. Corrigan Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-18 1934

22. I HEREBY CERTIFY, That I attended deceased from 8-17 1934 to 8-18 1934

I last saw him alive on 8-18 1934. Death is said to have occurred on the date stated above, at 7:50 P.M.

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

Bilateral Pulmonary  
131 pneumonia

136K  
1115

Other contributory causes of importance:  
Chronic Glomerulonephritis  
Uremia

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) P. C. Turner M.D. or R. C. Spring 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.

