

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

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OCT 17 1934

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Lean Primary Registration District No. 1000  
 City Kansas City (No. General Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Verd Mae Woodward  
 (a) Residence, No. Kansas Home St. Ward \_\_\_\_\_  
 (Usual place of abode) (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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-7-1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
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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) Kansas City

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Record Clerk, K.C. General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph's 9/25/34

19. UNDERTAKER (ADDRESS) St. Joseph's

20. FILED 9-25-34 Emm Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-21-1934

22. I HEREBY CERTIFY, That I attended deceased from 9-18-1934 to 9-21-1934

I last saw her alive on 9-21-1934 Death is said to have occurred on the date stated above, at 7:45 P.M.

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

Prematurity Date of onset \_\_\_\_\_

159  
 Other contributory causes of importance: 159

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

(Signed) J. J. [Signature] M. D.  
 (Address) St. Joseph's Hospital

N. B.—Every item of information shown here 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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