

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

Do not use this space.

39329

4531

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 3007
City Kansas City (No. 3519 East 28th Street St. _____ Ward _____)

2. FULL NAME Mrs. Ella D. Felty
3519 E. 28th St.

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>7-1-1865</u>		
7. AGE YEARS 69	MONTHS 4	DAYS 0
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home	
	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) Indiana		
FATHER	13. NAME J. S. Burdick	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana	
MOTHER	15. MAIDEN NAME Don't know	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know	
17. INFORMANT <u>Mrs. C. W. Decker</u> (ADDRESS) <u>3519 E. 28th St.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Mt. Moriah</u> DATE <u>Nov. 3, 1934</u>		
19. UNDERTAKER <u>Freeman Mortuary & Chapel</u> (ADDRESS) <u>104 West 42nd Street</u>		
20. FILED <u>11-3</u> 19 <u>34</u> <u>am on Crow</u> <u>aset</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 1**, 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1934, to Nov 1, 1934
I last saw her alive on Nov 1, 1934 Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Fracture of Rt Femur Date of onset June 30
Respiratory fracture Oct 25
Chronic Bronchitis 3 yrs
Old age

Other contributory causes of importance:
Chronic Bronchitis 3 yrs
Old age

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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 fell in saw M. D. _____
(Signed) W. M. Sams
(Address) 2400 E. 28th St.

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.

WHITE PAPER, WITH GRADING INK—THIS IS A PERMANENT RECORD

2400 Cypress

Dr. Wm. Lomas

1:30 P.M.

DEC 18 1934

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County JacksonTownship KawCity K 68thRegistration District No. 399Primary Registration District No. 1002No. 3519.628 Other

File No. _____

Registered No. 4831

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ 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 Fe 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

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

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

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) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 11-3-1934 M. M. Crowe Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 1st, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Fracture of Rt Femur [Date of onset _____]Other contributory causes of importance: Chronic Bronchitis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? accident Date of injury June, 1934Where did injury occur? at home in second city

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. fall in homeManner of injury fall in homeNature of injury fracture of right femur not recognized and missed until October24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) W. M. Sams, M. D.(Address) 2100 express

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

