

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.

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

Do not use this space.

1136

**1. PLACE OF DEATH**

County Tackson Registration District No. 399  
 Township Kaw Primary Registration District No. 1002  
 City Kansas City (No. 7140 Washington) St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
 Registered No. 2

**2. FULL NAME**

Mrs. Marian Wright Joyce  
 (a) Residence, No. 7140 Washington St., \_\_\_\_\_ Ward.  
 (Usual place of abode)

Length of residence in city or town where death occurred 33 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>deceased Creed Joyce</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 16 1901</u>		
7. AGE	YEARS <u>33</u>	MONTHS <u>0</u>
	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	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) <u>Kansas City Mo</u>		
FATHER	13. NAME <u>A. F. Wright</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
MOTHER	15. MAIDEN NAME <u>Mary Spruill</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
17. INFORMANT (ADDRESS) <u>A. Creed Joyce 7140 Washington</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Forest Hill</u> DATE <u>1-3</u> 19 <u>35</u>		
19. UNDERTAKER (ADDRESS) <u>D. W. Newcomer's Sons 211 East 9th St</u>		
20. FILED <u>Jan 1</u> 19 <u>35</u> M. M. Corouel Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 26 1934 to Jan 1 1935, 1935  
 I last saw her alive on Jan 1 1935. Death is said to have occurred on the date stated above, at 10:25 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage  
8201  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Cerebral Arterio sclerosis  
Arterial Hypertension  
Rupture of anterior Cerebral Artery

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Autopsy 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) Carl R. Ferris, M. D.  
 (Address) 934 Angyle Bldg

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THE UNITED STATES OF AMERICA  
 DEPARTMENT OF THE ARMY  
 OFFICE OF THE CHIEF OF STAFF  
 WASHINGTON, D. C.

MEMORANDUM FOR THE RECORD  
 SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint and illegible text, likely a memorandum or report.]