

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.

APR 26 1935

9293

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Four Primary Registration District No. 1002
City Kansas (No. 5-4-5) Park St. _____ Ward _____

2. FULL NAME

Meda Maria Durfee
(a) Residence, No. 545 Park 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 3 1930</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<u>4</u>	<u>7</u>	<u>18</u>	
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..... <u>Child</u>			
	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 Kansas</u>				
FATHER	13. NAME <u>Ray Durfee</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nebraska</u>			
MOTHER	15. MAIDEN NAME <u>Madeline Beck</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nebraska</u>			
17. INFORMANT <u>Ray Durfee</u> (ADDRESS) <u>545 Park K.C.Mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Mt Calvary H.C.K.</u> DATE <u>3-23-35</u> , 19__				
19. UNDERTAKER <u>Passantino Mo</u> (ADDRESS) <u>K.C.Mo</u>				
20. FILED <u>3-22 1935</u> <u>M.M. Crowson</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/21/35, 19__

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:
Congenital heart disease Date of onset _____

Other contributory causes of importance: no

Name of operation Ankyra Date 3/21/35

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 _____
(Signed) [Signature], M. D.
(Address) _____

