

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

APR 26 1935

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

Do not use this space.

9372

1. PLACE OF DEATH

County Jackson Registration District No. 000 File No. 1233  
Township Blue Primary Registration District No. 000 Registered No. 1233  
City Kennett Mo. (No. Leeds T. B. Hospital) (Ward)

2. FULL NAME

Mrs. Hester Elvin  
(a) Residence, No. 316 - Ewing St.,          Ward.           
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. George Elvin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9, 1897

7. AGE YEARS 38 MONTHS 0 DAYS 17 If LESS than 1 day,          hrs. or          min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
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) Mo.

MOTHER 13. NAME Syris Forest

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

15. MAIDEN NAME Rose Alexander

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

17. INFORMANT K. C. T. B. Hospital, Leeds Mo. (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Mar. 29-35 19.

19. UNDERTAKER C. H. Blackman & Son, Inc. (ADDRESS) 2825 Inden Blvd. K. C. Mo.

20. FILED 3/27 1935 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1935

22. I HEREBY CERTIFY, That I attended deceased from March 13, 1935 to March 26, 1935  
I last saw h. e. y. alive on March 26, 1935. Death is said to have occurred on the date stated above, at 3:40 p.m.

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

Pulmonary tuberculosis Date of onset 1933

Other contributory causes of importance: none

Name of operation none Date of           
What test confirmed diagnosis? X-ray Sputum Was there an autopsy? no

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) J. S. Hoffman M. D.  
(Address) K. C. Tuberculosis Hospital, Leeds, Mo.

