

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.

MAY 24 1935

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

Do not use this space.

12766

1. PLACE OF DEATH

County Jackson Registration District No. 308
Township Lead Primary Registration District No. 1202
City Kansas City (No. 1601-2nd) St. _____ Ward _____

File No. _____
Registered No. 14572. FULL NAME Litha Nancy

(a) Residence, No. 1601-2nd St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 20-1860</u>		
7. AGE	YEARS	MONTHS
<u>74</u>	<u>5</u>	<u>14</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>Ill.</u>		
FATHER	13. NAME <u>Patrick Dixon</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record.</u>	
MOTHER	15. MAIDEN NAME <u>Nancy Mike</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record.</u>	
17. INFORMANT <u>Mrs Mike Murphy</u> (ADDRESS) <u>1601-2nd</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Benson Ill.</u> DATE <u>4-4</u> 19 <u>35</u>		
19. UNDERTAKER <u>Shiel General Home</u> (ADDRESS) <u>6606-Independence Av</u>		
20. FILED <u>4-5</u> 19 <u>35</u> <u>M. M. Crow, asst</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>4/35</u>	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: <u>Brain sclerosis</u> <u>Chronic fibrous myocarditis</u>	
Other contributory causes of importance: <u>93 to</u>	
Name of operation _____	Date of ops _____
What test confirmed diagnosis? <u>Autopsy</u> 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) <u>[Signature]</u> , M. D.	
(Address) <u>[Signature]</u>	

