

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.

16-232

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

Do not use this space.

16717

1. PLACE OF DEATH

County Jackson  
Township Traver  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. 3834 Traver)

File No. \_\_\_\_\_  
Registered No. 2230  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Deborah Jane Lloyd

(a) Residence, No. 3834 Traver St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Unusual 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>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>4-16-1854</u>		
7. AGE YEARS <u>81</u>	MONTHS <u>1</u>	DAYS <u>13</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>House wife</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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-29 1935

22. I HEREBY CERTIFY, That I attended deceased from

May 18, 1935, to May 29, 1935  
I last saw h. alive on May 28, 1935. Death is said to have occurred on the date stated above, at 7:30 a.m.

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

Coronary Sclerosis. Date of onset \_\_\_\_\_  
May 18 1935 had an attack of Angina pectoris 1st stage  
May 19 acute pulmonary Oedema.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) L. H. Taylor, M. D.  
(Address) 3725 Harrison St.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Warsaw Ills</u>
	13. NAME <u>James Muchmore Here</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
	15. MAIDEN NAME <u>Sarah Calvin</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
17. INFORMANT (ADDRESS) <u>May Jones</u> <u>3834 Traver</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>McWashingtn</u> DATE <u>5/31/35</u> 19____	
19. UNDERTAKER (ADDRESS) <u>O. V. MAST FUNERAL HOME, Inc.</u> <u>3146 main st</u>	
20. FILED <u>May 30</u> , 19 <u>35</u> <u>M. M. Brown</u> Registrar.	

W. L. Taylor 20411.

3738 Harrison