

JUL 2 2 1935

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

Do not use this space.

16749

1. PLACE OF DEATH

County Jackson
Township Franklin
City J.C. Mo. (No. General Hosp #2)

Registration District No. 399
Primary Registration District No. 3002

File No. _____
Registered No. _____
St. 3208 (Ward)

2. FULL NAME

(a) Residence, No. 1414 Gracy 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 Female
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-14-1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
31 7 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework
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.

13. NAME Robert Harding

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laurens Ks

15. MAIDEN NAME Hatty Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laurens Ks

17. INFORMANT (ADDRESS) Mrs. English
1218 N. 12th St

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Cem DATE 6-4-35

19. UNDERTAKER (ADDRESS) F.B. Moore
1620 E 18th St

20. FILED 6-3 1935 M.M. Crowe, reg Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 5-23 1935 to 5-29 1935

I last saw her alive on 5-29 1935 Death is said to have occurred on the date stated above, at 12⁰⁰ A.M.

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

Basilar Meningitis
Specific
Epidemic Type
Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) A. O. Jones, M. D.

(Address) General Hosp. #2

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.

1. PLACE OF DEATH

County Jackson
Township _____
City Kansas City (No. _____)

Registration District No. 399
Primary Registration District No. 1002
Special Hosp. # 2

File No. 16749
Registered No. 3278
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ 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 F. 4. COLOR OR RACE B. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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

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

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

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.
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)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED 6/3 25 Th. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 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:

Acute Bacterial Meningitis (Specific) Date of onset _____

Other contributory causes of importance:

Specific in this case does not mean typhoid, but epidemic in form due to meningococcus

Name of operation _____ Date _____
What test confirmed diagnosis? infectious 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, 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) D. C. Lutzner, M. D.

(Address) Gen'l. Hosp # 2

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township General Hosp #2 Primary Registration District No. 1007
 City Kansas City (No. General Hosp #2)

File No. 16749
 Registered No. 2778 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1414 Tracy St., _____ Ward _____

(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 F 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

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

7. AGE YEARS 31 MONTHS 7 DAYS 15 If less than 1 year, min.

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

9. Industry or business in which work was done, as mill, saw mill, bank, etc.

10. Date deceased first worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME Larsh Nash

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 6/3 1935 M. M. Grove Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I 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:

Basilary Meningitis Date of onset _____

Specific

Epidemic type

Other contributory causes of importance:

Epidemic

Meningococcus

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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 5-29, 1935

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) P. J. Turner M. D.

(Address) General Hosp No 2

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.