

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

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.

DEC 26 1935

36056

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Gran Primary Registration District No. _____
City Kansas City (No. K.C. General Hosp) _____ St. _____ Ward _____

File No. 1229
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3408 E 97 1/2 nd St. St. _____ Ward _____

(Usual place of abode) _____ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 25 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 W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-1-1893

7. AGE YEARS 42 MONTHS 1 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housework
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 FATHER 13. NAME Albert Dolbe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

MOTHER 15. MAIDEN NAME no record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

17. INFORMANT (ADDRESS) Reverend Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE St Mary's DATE Nov-11-1935

19. UNDERTAKER (ADDRESS) Mar J S Porter

20. FILED Nov 10 1935 M. M. Cooney, Asst Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-9-1935

22. I HEREBY CERTIFY, That I attended deceased from 9-27-35 to 11-9-35

I last saw her alive on 11-9-35 Death is said to have occurred on the date stated above, at 2:15 PM

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

Acute Cystitis Ascending Pyelonephritis
1935

Date of onset

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? _____

If so, specify _____

(Signed) J H Bennett M.D.

(Address) 514 K C General Hosp M. D.

