

JAN 23 1936

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

Do not use this space.

39823

1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No. 1000

Township Leeds

Primary Registration District No. 1002

Registered No. 1000

City Leeds (No. 1002)

Tuberculosis Hosp St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2106 Vine 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25 1890

7. AGE YEARS 45 MONTHS 0 DAYS 2 IF LESS than 1 day, _____ hrs. or _____ min.

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

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) Wellington Mo

13. NAME Grant, Spencer

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

15. MAIDEN NAME Young, Lattie

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

17. INFORMANT (ADDRESS) K. C. J. Hosp.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 12/31 1935

19. UNDERTAKER (ADDRESS) Pathologist T. Brod. 1729 Lydia

20. FILED Dec 30 1935 M. M. Cronin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27 1935

22. I HEREBY CERTIFY that I attended deceased from Jan 24 1935 to December 27 1935

I last saw her alive on Dec 27 1935 Death is said to have occurred on the date stated above, at 5:25 P.M.

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

pulmonary tuberculosis Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? positive X-ray 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. Hoffmann M. D.
(Address) 13 Hospital
Leeds, Mo.

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.

