

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.

JUL 24 1936

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

Do not use this space.

22981

## 1. PLACE OF DEATH

County Jackson Registration District No. 399  
Township Raw Primary Registration District No. 1002  
City K.C. Mo (No. St. Louis Hospital)  
St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 2013  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(a) Residence, No. Independence Mo Ward Independ. Mo  
(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 <u>F</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Remarried</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>June 10, 1898 Unknown</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE <u>38</u>	YEARS	MONTHS <u>0</u>	DAYS <u>8</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</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.....				
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Stanley Kans</u>			
	13. NAME <u>John M. Gray</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>			
	15. MAIDEN NAME <u>Koberta Prather</u>			
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>			
	17. INFORMANT (ADDRESS) <u>Hospital Records</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Olathe, Mo</u> DATE <u>6-18 1936</u>				
19. UNDERTAKER (ADDRESS) <u>Martin W. Frye</u> <u>618 1/2 N. M. Brown</u>				
20. FILED <u>18, 1936</u> <u>M. M. Brown</u> Registrar.				

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-18 1936

22. I HEREBY CERTIFY, That I attended deceased from 6-7-36, 1936, to 6-18, 1936.  
I last saw her alive on 6-18, 1936. Death is said to have occurred on the date stated above, at 6<sup>00</sup> a.m.  
The principal cause of death and related causes of importance were as follows:  
Relational Salpingitis acute purulent Date of onset 4-7-36  
Septic following relational laceration of cervix  
Other contributory causes of importance  
Relational Salpingitis  
Name of operation Salpingectomy Date of 6-9-36  
What test confirmed diagnosis? Op. 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) H. P. Kuhn, M. D.  
(Address) 5431 Mission Dr.



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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Reyno Primary Registration District No. 1002  
 City Reyno (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 2913

**2. FULL NAME**

Florence Clark  
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 10 (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 MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
38 0 8

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)

13. NAME

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

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 6/18 36 J. M. Grove  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-18 1936

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him/her fall 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: Date of onset

Acute peritonitis  
(Not Puerperal)  
Secondary or tuberculous

Other contributory causes of importance:

Bilateral Salpingitis  
Septic following bilateral  
Excision of Cervix

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_ (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) H. P. Kuhn, M. D.  
 (Address) \_\_\_\_\_

SUPPLEMENT

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.

RECORD

5-72981