

MAR 13 1937

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

Do not use this space.

## 1. PLACE OF DEATH

County *Jackson*  
Township *New*  
City *Kansas city* (No. *2500, East 30th St*)

Registration District No. *399*  
Primary Registration District No. *1002*

File No. *6387*  
Registered No. *1025*  
St. *8th* Ward

## 2. FULL NAME

*Mrs Minnie Macomber*  
(a) Residence, No. *2500 East 30th* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 11 1853*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*83 6 0*

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

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) *Ohio*13. NAME *Lyman South*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*15. MAIDEN NAME *Don't know*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*17. INFORMANT (ADDRESS) *Mrs Gladys Macomber 2500 East 30th St*18. BURIAL, CREMATION, OR REMOVAL PLACE *Tray Kansas* DATE *Feb 11 1937*19. UNDERTAKER (ADDRESS) *Wheeler Mortuary Kansas city mo*20. FILED *2-11 1937* *M. M. Crowe, Reg.*

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 11 1937*22. I HEREBY CERTIFY, That I attended deceased from *Feb 7 1937* to *Feb 11 1937*

I last saw her alive on *Feb 11 1937* 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:

*Bronchopneumonia* Date of onset

Other contributory causes of importance:

*Acute suppression of urine of chronic nephritis*Name of operation *none* Date of.....What test confirmed diagnosis *ditto* 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 *no*(Signed) *M. M. Crowe* M. D.(Address) *818 Ralls Bldg*

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.

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