

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17-71

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

Do not use this space. †

**MAY 15 1937**

15305

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Raw Primary Registration District No. 109  
 City Kansas City, Mo. University Park Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mrs Joe Edna Chick  
 (a) Residence, No. 916 Washington Ward \_\_\_\_\_  
 (Usual place of abode)  
 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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF <u>Chas R. Chick</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>6-5-1912</u>		
7. AGE YEARS <u>24</u>	MONTHS <u>9 mo</u>	DAYS <u>13</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 wife</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 _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Creck Mo</u>		
FATHER	13. NAME <u>Thompson</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ray County Mo</u>	
MOTHER	15. MAIDEN NAME <u>Knutter</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ray Co Mo</u>	
17. INFORMANT (ADDRESS) <u>Chas R. Chick</u> <u>916 Washington</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Floral Home</u> DATE <u>4/20/37</u>		
19. UNDERTAKER (ADDRESS) <u>D. V. EAST FUNERAL HOME, INC</u> <u>2146 Main St</u>		
20. FILED <u>Apr 19 1937 M. M. Cronow</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18-1937

22. I HEREBY CERTIFY, That I attended deceased from 4-8-1937 to 4-18-1937, 1937  
 I last saw him alive on 4-17-1937. Death is said to have occurred on the date stated above, at 10 a m.  
 The principal cause of death and related causes of importance were as follows:  
Peritonitis Date of onset 4-7-37  
139 Bl  
 Other contributory causes of importance:   
Bilateral Tubo-ovian abscesses. 8-1-37  
 Name of operation Tubectomy Date of 4-8-37  
 What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) J. Sheldon, M. D.  
 (Address) 822 Walnut  
St. Louis, Mo.



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

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**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 15305  
 Township Stangas City Primary Registration District No. 51100Y Registered No. 1851  
 City Stangas City No. Vineyard Park Hospital St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence, No. Mrs. Joe Edna Chick Ward. \_\_\_\_\_  
 (Usual place of abode) 916 Washington

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Mar (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.  
24

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 4/19 37 M. M. Brown Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 18 1937

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

I last saw h. \_\_\_\_\_ 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:  
Peritonitis Date of onset 134131

Wound - Perforated Colon (Basil + Stepi)

Other contributory causes of importance:  
Bilateral Sub-ovarian abscesses

Name of operation Laparotomy Date of 4-9-37  
 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? \_\_\_\_\_ (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. S. Sheldon \_\_\_\_\_, M. D.  
 (Address) 927 Walnut

**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.

5-15305