

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.

JUN 12 1937

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

Do not use this space.

19052

1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. 3423 Olive)

File No. \_\_\_\_\_  
Registered No. 2205  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

2. FULL NAME

ALBETA HENRY

(a) Residence, No. 3423 Olive St. \_\_\_\_\_ 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. (If nonresident, give city or town and State)

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 I. N. Henry

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 23, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
71 9 24

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) Iowa

13. NAME Orin Turner

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

15. MAIDEN NAME Amanda Brasher

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

17. INFORMANT J. N. Henry (Son)  
(ADDRESS) 3423 Olive

18. BURIAL, CREMATION OR REMOVAL PLACE Forest Hill Gemetery  
Kansas City, Mo. DATE May - 19 1937

19. UNDERTAKER Stine & McClure  
(ADDRESS) 3235 Gilham Plaza

20. FILED May 17, 1937 M. M. Brown  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17 1937

22. I HEREBY CERTIFY, That I attended deceased from 1-13- 1937, to 5-17- 1937.

I last saw him alive on 5-17- 1937. Death is said to have occurred on the date stated above, at A. M. 2:40

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

Lobar Pneumonia  
Rt. Lower

Date of onset

Other contributory causes of importance:  
Arteriosclerosis  
Hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Asmet 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) Smith & Bleck M. D.  
(Address) 924 Prof. Bldg.  
K. C. Mo.

Craft Bld. 1/2/1

018481

3 Pm.