

SEP 21 1937

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

Do not use this space.

29807

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Jackson Primary Registration District No. 1002
City J.R.C. Mo. (No. General Hosp. #2) (Ward) 9th

2. FULL NAME

(a) Residence, No. 326 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 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>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>unk 1890</u>		
7. AGE	YEARS	MONTHS
<u>30</u>	<u>47</u>	<u>—</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Domestic</u>		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Miss.</u>		
13. NAME <u>deceased</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS) <u>Record Clerk</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>West Lawn</u> DATE <u>Aug 19 - 37</u>		
19. UNDERTAKER (ADDRESS) <u>E. J. Stinking, 1116 1/2 St.</u>		
20. FILED <u>Aug 29 1937</u> <u>M. M. Crowe, reg.</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17 1937

22. I HEREBY CERTIFY, That I attended deceased from 8-15 1937, to 8-17 1937.
I last saw her alive on 8-17 1937. Death is said to have occurred on the date stated above, at 1:40 P. M.
The principal cause of death and related causes of importance were as follows:
Hypertensive type
Heart disease
Other contributory causes of importance 95B
Cerebral apoplexy

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical 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. A. Turner M. D.
(Address) General Hosp.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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