

DEED OCT 15 1938

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

31526  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002 Registered No. 3823  
(c) City Kansas City, Mo. (d) Street No. 1104 Park Avenue, K.C. Mo. St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kathryn Mary Dotson, 325

(a) Residence, No. 1104 Park Avenue, K. C. Mo. St.  \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 31st, 1865

7. AGE YEARS 73 MONTHS \_\_\_\_\_ DAYS 29 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. At Home  
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) West Virginia

FATHER 13. NAME James Dougherty,

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

MOTHER 15. MAIDEN NAME Mary Pickett

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

17. INFORMANT Adalaska Dotson,  
(ADDRESS) 1104 Park Avenue, K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Elmwood Cemetery DATE Oct. 1st, 1938

19. FUNERAL DIRECTOR (NAME) Mrs. C. L. Forster  
(ADDRESS) 918 Brooklyn Avenue, K.C. Mo.

20. FILED Oct 2 1938 M. M. Crowe  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 29th, 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1938, to Sept 28, 1938.  
I last saw her alive on Sept 28, 1938. Death is said to have occurred on the date stated above, at 8:30 P.M.  
The principal cause of death and related causes of importance were as follows:

Coronary thrombosis

Date of onset

8-1-38

Other contributory causes of importance:

Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? yes

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) C. L. Forster, M. D.

(Address) 507 Monroe St.

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.

8241

see at his office  
12 noon Sat.

507 Commerce Bldg.  
Vic: 9171.  
Res. Log: 6160.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

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

31526 -  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township ..... Primary Registration District No. 1222  
 (c) City K.C. (d) Street No. — Registered No. 3823 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kathryn M. Danson  
 (a) Residence, No. 1124 P. Gate St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m.

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.
<u>73</u>	<u>—</u>	<u>29</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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)

FATHER

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

MOTHER

15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED 10/2/38 W. M. Crowe Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 29, 1938

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:  
Cerebral hemorrhage Date of onset 12/1

Other contributory causes of importance:  
Uremia  
Chronic Nephritis 4-18-38

Name of operation..... Date of.....  
 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) Carl A. Jackson, M. D.  
 (Address) 527 Commerce

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.

