

REC'D MAY 10 1939

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

13679
Do not use this space.
1433

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 309
 (b) Township Raw Primary Registration District No. 1002 Registered No. 1433
 (c) City Kansas City (d) Street No. 1720 E. 11th 2nd floor 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 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kate Harris
 (a) Residence, No. 1720 E. 11th 2nd floor 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 Fe 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk 1867

7. AGE YEARS 72 MONTHS — DAYS — If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic
 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) Minden La.

FATHER 13. NAME unk Jones
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Minden La.

MOTHER 15. MAIDEN NAME Elizabeth unk
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Minden La.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 25, 1939, to April 3, 1939
 I last saw h. unk alive on April 3, 1939. Death is said to have occurred on the date stated above, at 6 A. m.
 The principal cause of death and related causes of importance were as follows:
Blood Poison 115B 3/20-39
Infected teeth

Other contributory causes of importance:
none

Name of operation none Date of —
 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) Walter Paul M. D.
 (Address) 703 Waldwin Bldg

17. INFORMANT (ADDRESS) Warren Webb. 2116 E. 16th

18. BURIAL, CREMATION, OR REMOVAL PLACE Shreveport La DATE 4-4 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Adkins Bros 13708 2000 E. 12th

20. FILED Apr 7 1939 m m. Crow, clerk Local Registrar

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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.

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 _____

Edw Evans

Licensed Embalmer No. _____

3836

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.