

REC'D JUL 10 1939

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

21140

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 1002
(c) City St. C. Mo. (d) Street No. General Hospital #2 Registered No. 2418
(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

Hattie Traylor (Hattie Traylor)
(a) Residence, No. 1010 Frost (Raw) 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo. Steel

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 14 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 7 7 hr

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) Georgia

13. NAME Richard Lawson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Katie Bonds

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

17. INFORMANT (ADDRESS) Record Clerk General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE 6-13-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) West, opposite

20. FILED 6/12 39 M. M. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-3 19 39

22. I HEREBY CERTIFY, That I attended deceased from 1-20 19 39 to 6-3 19 39

I last saw her alive on 6-3 19 39. Death is said to have occurred on the date stated above, at 9:00 AM.
The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy

Date of onset

Other contributory causes of importance:
Essential Hypertension

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) G. Turner, M. D.

(Address) General Hospital #2

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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5014-1-12-38

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
EMBALMERS' CERTIFICATE

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 G. J. West,

Licensed Embalmer No. 2210

P. O. Address K. C. M. D.

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.