

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 389
Primary Registration District No. 1002
(No. 704 Brighton Ward)

File No. 33145
Registered No. 4079
St. 4079 Ward

2. FULL NAME Mrs. Nancy Belle McGinnis

(a) Residence. No. 704 Brighton Ave. 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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Divorced

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

Brick Balmory McGinnis

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

Nov. 3, 1877

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day,hrs. ormin.

55

11

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Nurse

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) St. Louis, Missouri

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dont Know

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dont Know

14.

INFORMANT Mrs. R. S. Trone

(Address) 704 Brighton K. C. Mo

15.

FILED 10-16-33 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 15 '33 19

17.

I HEREBY CERTIFY, That I attended deceased from

10/12, 1933, to 10/15, 1933

that I last saw him alive on 10/15, 1933, and that death occurred, on the date stated above, at 10:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicæmia "Fox Throat"
Myocarditis
Bronchial Pneumonia

CONTRIBUTORY (SECONDARY)

Toxic Thyroid
113 A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Lab + Clinical

(Signed) Dr. Freeman, M. D.

, 19 (Address) 10307 Andipark KCMO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Memorial Park

DATE OF BURIAL

10/17 19 33

20. UNDERTAKER

Freeman Mortuary

ADDRESS

K. C. Mo

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.

NOV 10 1933

