

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

Do not use this space.

11965

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City Mo

Registration District No. 399
Primary Registration District No. 1002

File No. 1701
Registered No. 1701
St. Camptell Ward

2. FULL NAME

Elizabeth Daniels
(a) Residence. No. 2115 a Campbell St. Ward.
(Usual place of abode)
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE negro. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-10-1905

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>21</u>	<u>10</u>	<u>18</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Kitchen Help.
(b) General nature of industry, business, or establishment in which employed (or employer) Woolworth store
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kear
(STATE OR COUNTRY) Mo

10. NAME OF FATHER James Daniels

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sherman
(STATE OR COUNTRY) Texas

12. MAIDEN NAME OF MOTHER Maria Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kear
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs L. Pittender
(Address) 2115 a Campbell

15. FILED 4/29, 1927 M. M. Crome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28-27

17. I HEREBY CERTIFY That I attended deceased from 4-10-1927, to 4-28-1927, that I last saw h.c. alive on 4-28-1927, and that death occurred, on the date stated above, at 7 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
R. S. A.

Post-mortem Tuberculosis
(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. 5 mos. 5 ds.

18. WHERE WAS DEATH CONTACTED
IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Laboratory & Physical

(Signed) L. H. Booker, M. D.
4/29, 1927 (Address) 2128 - Vine St

*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 Maple Hill DATE OF BURIAL 4-30-27

20. UNDERTAKER Sumner Son ADDRESS 100 R

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.

