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

Do not use this space.

345
40964

File No.
Registered No.

1. PLACE OF DEATH
County: Jackson
Township: Law
City: Kansas, Mo (No. Old City Hosp St. Ward)
Registration District No. 399
Primary Registration District No. 1002

2. FULL NAME: Divers, Amy
(a) Residence. No. 4104 Holmes St., 6 Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Forever 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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. Nov 1848

7. AGE: 80 (?) Years; Months: 4 mo; Days: Nov; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(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): Johnson Co. Mo

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Divers, Julia
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Patients employers
(Address) 4104 Holmes

15. FILED 12-22-28 19 MM Crowl
a est REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21- 1928

17. I HEREBY CERTIFY, That I attended deceased from 12-18 19 28 to 12-21 19 28 that I last saw h. alive on 12-21 19 28 and that death occurred, on the date stated above, at 7:10 A.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
I. Lobar Pneumonia (Bilateral) (Complete delirium)
10 d
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Uterine Fibromyoma
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Home
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & laboratory
(Signed) Supt. H. M. Smith, M.D.
12-24 19 28 (Address) Old City Hospital

*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: Belle Rieger Lawn
DATE OF BURIAL: 12-24 1928

20. UNDERTAKER: West Appleton & Jones
ADDRESS: 1600 E 17

# MISSOURI STATE BOARD OF HEALTH
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### CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County ..... Registration District No. 399 File No. .....

Township K. City Primary Registration District No. 1002 Registered No. 5345

City ..... (No. ....., ..... St. ..... Ward)

2. FULL NAME Amy Divers

(a) Residence. No. ..... 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 F
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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.

8. OCCUPATION OF DECEASED

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

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21-1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ....., 19..., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

I Lobar pneumonia

1010

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Uterine Fibroma Non malignant (duration) ..... yrs. ..... mos. ..... ds.

This fibroma was not malignant just a fibroid tumor

...AS DISEASE CONTRACTED

... AT PLACE OF DEATH? .....

...PERATION PRECEDE DEATH? ..... DATE OF .....

...RE AN AUTOPSY? .....

...ST CONFIRMED DIAGNOSIS? .....

...ned) ....., M. D

19 (Address)

*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.

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

14. INFORMANT .....
(Address)

15. FILED 12/22 1928 M. M. Brown REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-40964
1928