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

Do not use this space.

6607

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. [illegible]

Township Kaw — Primary Registration District No. 1002 — Registered No. 882

City Kansas City (No. General Hosp. H 2 St. Ward)

2. FULL NAME Williamson, Hattie

(a) Residence. No. 1321 Paseo St., 2 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 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: 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) Oct. 20, 1904

7. AGE: Years 24 — Months 3 — Days 20 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: maid
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Coates Hotel

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Alabama

2

PARENTS

10. NAME OF FATHER: Hutchinson, Henry
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Georgia
12. MAIDEN NAME OF MOTHER: Jackson, Mary
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Alabama

14. INFORMANT: Denrex, Margaret
(Address) 514 Forest

15. FILED 2-16, 1929 M M Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-10-1929

17. I HEREBY CERTIFY, That I attended deceased from 1-5-, 1929, to 2-10, 1929 that I last saw her alive on 2-10, 1929, and that death occurred, on the date stated above, at 3 50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute caseous Pneumonia
Pneumonary Tuberculosis
23A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Cachexia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical and laboratory

(Signed) H. M. Smith, M. D.

2/11, 1929 (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: Highland Cem. — DATE OF BURIAL: 2-19-1929

20. UNDERTAKER: H. B. Moore — ADDRESS: 1820 E 18

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD