

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

Do not use this space.

24895

3312

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Kaw

Primary Registration District No. 1002

City Kansas City (No. Gen. Hosp. No. 2)

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1215 Woodland 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 <u>Female</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gray, James</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct. 10, 1908</u>				
7. AGE	YEARS <u>20</u>	MONTHS <u>9</u>	DAYS <u>15</u>	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Demons, Iowa
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Duval, A. D.</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Pittsburg</u> (STATE OR COUNTRY) <u>Penn.</u>
	12. MAIDEN NAME OF MOTHER <u>Shanklin, Louise</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Austin</u> (STATE OR COUNTRY) <u>Texas</u>

14. INFORMANT Record Clerk
(Address) K.C. Gen. Hosp. # 2

15. FILED 8/2 1929 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1929
17. I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 25, 1929, that I last saw her alive on July 25, 1929, and that death occurred, on the date stated above, at 11:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute pneumonic tuberculosis
VBA

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 21
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Sputum
(Signed) H. M. Smith, M. D.

7-27 1929 (Address) K.C. Gen. Hosp. No. 2
*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 <u>Blue Ridge Lawn</u>	DATE OF BURIAL <u>8-3 1929</u>
20. UNDERTAKER <u>West Appleton + Jones</u>	ADDRESS <u>1600 E 19th</u>

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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