

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

Do not use this space.

30806

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 3820
 City Kansas City (No. 3845 Baltimore) St. _____ Ward _____

2. FULL NAME Marianna Alexander
 (a) Residence. No. 3845 Baltimore St. 5 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 1, 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 1 9

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

9. BIRTHPLACE (CITY OR TOWN) St. Clairsville
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Ross J. Alexander

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Clairsville
 (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Margaretta Askew

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

14. INFORMANT St. Clair Alexander
 (Address) 3845 Baltimore

15. FILED 9/11, 1929 M. M. Greene
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-10 1929
 17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1929 to Sept 10 1929 that I last saw her alive on 9-10 1929 and that death occurred, on the date stated above, at 4:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis with
irritation of heart

CONTRIBUTORY (SECONDARY) Chronic Hypertosis
 (duration) 6 yrs. 6 mos. 1 ds.
 (duration) 3 yrs. 3 mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH 9015

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Subaratorg. & ray Autops
Saw Day M. D.

(Signed) _____
9-10 1929 (Address) 814 Argyle Bldg

*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 St. Clairsville, Ohio DATE OF BURIAL 9-11- 1929

20. UNDERTAKER Shue & McClure ADDRESS 3235 Hickham
Bluff

K. 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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