

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

Do not use this space.
33962
4415

1. PLACE OF BIRTH

County Jackson Registration District No. 399
Township Blaine Kaw Primary Registration District No. 1002
City Leeds, Mo. (No. Leeds Hospital)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ficker, Emma 12
(a) Residence No. 1539 Elmwood Ave - Ward
(Usual place of abode)

Length of residence in city or town where death occurred 6 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 10, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 5 16

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) Illinois
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Jackson Creel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill -
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Settle
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill -
(STATE OR COUNTRY)

14. INFORMANT H. C. T. P. Hospital
(Address)

15. FILED 10/26 1929 M. M. Crows REGISTRAR
ass't

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 26 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1929, to Oct. 26, 1929 that I last saw h alive on Oct. 26, 1929, and that death occurred, on the date stated above, at 10:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A (duration) _____ yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS macroscopical
(Signed) George V. Bee M. D.

10/26 1929 (Address) 1057 Engle Blk. R. 11
*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 Wendell Ill DATE OF BURIAL 10/26 29

20. UNDERTAKER W. Mast ADDRESS 1915 Post St

WRITE MAINLY, 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.

23A
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