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

Do not use this space.

1250

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 241
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas City Mo (No. Research Hos St. Ward)

2. FULL NAME Mattie May Brown
(a) Residence. No. 509 South Lawnsdale St. 10 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 14 — 1875

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
54	2	3	

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

235

9. BIRTHPLACE (CITY OR TOWN) De Mains
(STATE OR COUNTRY) Iowa

2

PARENTS
10. NAME OF FATHER William Arnold
11. BIRTHPLACE OF FATHER (CITY OR TOWN) dont Know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Elizabeth Spinsledge
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

31

10

14. INFORMANT John W Brown
(Address) 509 South Lawnsdale

15. FILED 1/18, 1930 M M Crowe REGISTRAR
asst

4

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 — 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-27, 1930, to 11 —, 1930 that I last saw her alive on Jan 17, 1930, and that death occurred, on the date stated above, at 7:45 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Endarteritis Obliterans with resulting gangrene of foot
59
99
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Glycosuria — arteriosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at Residence
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Wilson A Myers, M. D.
1/17, 1930 (Address) Shukert Bldg — K C Mo.

*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	DATE OF BURIAL
Mt Washington Cem	Jan 20 1930
20. UNDERTAKER	ADDRESS
John W Wagner 1409	Grand Ave

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.