

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

Do not use this space.

19434

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Kaw

Primary Registration District No. General Hospital

City Kennett (No. General Hospital)

File No. _____
Registered No. 2428 Ward _____

2. FULL NAME

(a) Residence. No. 1217 Woodlawn Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 6 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 6, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 - 7 - 4

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

9. BIRTHPLACE (CITY OR TOWN) Sheepport Pa. (STATE OR COUNTRY)

10. NAME OF FATHER Robert Carter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pa.

12. MAIDEN NAME OF MOTHER Cora Horner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pa.

14. INFORMANT Fyle Clerk (Address) General Hosp # 2

15. FILED 6/10 19 30 m. m. 6 REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9-30 19 30

17. I HEREBY CERTIFY, That I attended deceased from 6-4-30 19 30 that I last saw her alive on 6-9-30 19 30 and that death occurred, on the date stated above, at 8:55 Pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Robert Pneumonia
108 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10/10 (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
(Signed) Wm Smith M.D.
110 19 30 (Address) City Hosp # 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 Sheepport, Pa. DATE OF BURIAL June 11 1930

20. UNDERTAKER West Uppton ADDRESS 600 E 19 St

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

