

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.

Illegitimate

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

Do not use this space.

22933

1. PLACE OF DEATH

County Jackson
Township H.C. No
City H.C. No

Registration District No. _____
Primary Registration District No. _____
(No. Mercy Hospital)

File No. _____
Registered No. 2025
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3003 Woodland St. H Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. _____

(If nonresident, give city or town and State)
How long in U.S., if of foreign birth? yrs. mos. ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>3</u>		

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

9. BIRTHPLACE (CITY OR TOWN) 3003 Woodland
(STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Josephine Roach

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

14. INFORMANT Mrs Kent
(Address) Florence Cullison Home

15. FILED 7/15 30 3003 Woodland
M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH Sunday

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1930

17. I HEREBY CERTIFY, That I attended deceased from July 11 1930 to July 13 1930 that I last saw her alive on July 13 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Otitis media, Staphylococci
89A
31
(duration) 2 1/2 yrs. 2 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Staphylococci Septicemia
secondary to Otitis media (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Lab, clinical + autopsy
(Signed) S. Pakula M.D. M. D.

7/15 1930 (Address) Mercy Hospital

*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 Maple Hill DATE OF BURIAL 7-21 1930

20. UNDERTAKER Eglar Funeral Home ADDRESS 1800 Leinwood

