

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

Do not use this space, 15 2
23209 0 4

PLACE OF DEATH

County Jackson Registration District No. 400 File No. _____
Township Prarie Primary Registration District No. 5578 Registered No. 104
City Jackson County Home No. St. _____ Ward) _____
Little Blue Mo.

2. FULL NAME

(a) Residence. No. Jackson County Home St. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

—

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

unknown

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

unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

about 73

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

unknown

(c) Name of employer

unknown

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14. INFORMANT

(Address)

J. W. Hostetter
Little Blue, Mo.

15. FILED

19

7-29-30
M. S. James
REGISTRAR

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

July 26, 1930

17.

I HEREBY CERTIFY, That I attended deceased from

7-1

1930

to

7-26

1930

that I last saw h. or alive on 7-25, 1930, and that death occurred, on the date stated above, at 4:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic myocarditis

9:30

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (SECONDARY)

NO

(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

clinical

(Signed)

J. W. Green M. D.
1930 (Address) Independence 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

McCalvary Cemetery

7/29 1930

20. UNDERTAKER

ADDRESS

Kellenline

Kellenline

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, is very important. PHYSICIANS SHOULD STATE

281930

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