

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

Do not use this space.

399

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. Blank)

Registration District No. 1902  
Primary Registration District No. Blank

File No. 2675863  
Registered No. 3363  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1211 Michigan Apt 1 St. 7 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.  mos.  ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Female

**4. COLOR OR RACE**

Colored

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

Single

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

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

Unknown

**7. AGE**

YEARS 29

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

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

(c) Name of employer Atlas Candy

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Id.

**10. NAME OF FATHER**

Irish James

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Id.

**12. MAIDEN NAME OF MOTHER**

Johnson, Edith

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Id.

**14.**

INFORMANT (Address)

Hospitals Record

**15.**

FILED

8/13/30 M.M. Crowe  
asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Aug 9 1930

**17. I HEREBY CERTIFY, That I attended deceased from** 7-26, 1930, to 8-9, 1930, that I last saw h. w. alive on 7-7, 1930, and that death occurred, on the date stated above, at 7 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septicemia (Post-operative)  
Ronococcus Infection  
35H (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

40/13 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF 8-7-30

WAS THERE AN AUTOPSY?

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) H.M. Smith, M. D.

49 1930 (Address) General Hospital #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**

**DATE OF BURIAL**

Shrout Co

8- 1930

**20. UNDERTAKER**

**ADDRESS**

Wm. W. Lickner 1212 Wm

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.

