

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

Do not use this space.
5767
800

1. PLACE OF DEATH
 County JACKSON Registration District No. _____
 Township RAW Primary Registration District No. _____
 City KANSAS CITY? MO. (No. GENERAL HOSPITAL) St. _____ Ward _____

2. FULL NAME JESSIE GARCIA
 (a) Residence No. 2308 mercier 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE **4. COLOR OR RACE** MEX **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60

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) 235
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mexico 18

10. NAME OF FATHER Luzardo Ruiz

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

12. MAIDEN NAME OF MOTHER Jessie Luzardo

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

14. INFORMANT Fred Garcia
 (Address) 2308 Mercier

15. FILED 2/22 1931 M. McCraw REGISTRAR
card

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-20 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Engorged (duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY (SECONDARY) Chronic endocarditis (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 AT WHAT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
 (Signed) Reginald Corbin M.D.
2/20 1931 (Address) Reginald Corbin

*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 St Marys Cemetery **DATE OF BURIAL** 2/23 1931

20. UNDERTAKER Keller **ADDRESS** K. C. Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

