

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

Do not use this space.

19423

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. Mercy. hosp)

Registration District No. 389
Primary Registration District No. 1002

File No. _____
Registered No. 2827
St. _____ Ward _____

2. FULL NAME

Dorothy Ralston
(a) Residence No. 439 S. Bales St. 9 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

3. SEX female 4. COLOR OR RACE white 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) Nov. 9, 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
--- 6 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER James A. Ralston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Kans. 2
12. MAIDEN NAME OF MOTHER Georgia Vanhouse
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cherryvale
(STATE OR COUNTRY) Kans.

14. INFORMANT James A. Ralston
(Address) K C Mo

15. June 3, 1932 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/2/32 1932

17. I HEREBY CERTIFY, That I attended deceased from 5/30/32, 1932, to 6/2/32, 1932, that I last saw her alive on 6/2/32, 1932, and that death occurred, on the date stated above, at _____ m.

1575 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spina Bifida
(Myelo-meningocele)
1575 (duration) space with ds.
10/10 (duration) yr mos. 1 ds.
CONTRIBUTORY (SECONDARY) Surgical Shock

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. at home ①
DID AN OPERATION PRECEDE DEATH. Yes DATE OF 6/2/32
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS Exam - Autopsy
(Signed) Wm Howard, M. D.
4921932 (Address) Mary Hwy

*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 Mt. Calvary KCK DATE OF BURIAL 6/4 1932

20. UNDERTAKER Geo. H. Long ADDRESS K C K

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.

