JUL 22 1935

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

Do not use this space.

Gen:

399

19802

1. PLACE OF DEATH

County: Jackson — Registration District No.: 1002 — File No.:

Township: Kaw — Primary Registration District No.: — Registered No.:

City: K.C. Mo. (No. General Hospital # 2 St. Ward)

2. FULL NAME Mollie Stilson

(a) Residence, No. 433 W 67th 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

3. SEX: Female
4. COLOR OR RACE: Negro
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) Sept 6, 1888

7. AGE: Years 46 — Months 8 — Days 6 — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boonville Mo

FATHER

13. NAME Tom Stilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boonville Mo

MOTHER

15. MAIDEN NAME Mary Miles
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boonville Mo

17. INFORMANT (ADDRESS) Ella M. Gillman 1806 Tracy

18. BURIAL, CREMATION, OR REMOVAL PLACE Hoffman Cemetery DATE 6/13 1935

19. UNDERTAKER (ADDRESS) Julius Adk Fleisher

20. FILED June 14 1935 Mrs Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-13-1935

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..... I last saw h... alive on ..., 19..... Death is said to have occurred on the date stated above, at 4 P.M. The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal obstruction	
Acute peritonitis	

Other contributory causes of importance:

Name of operation: Autopsy Date of ...

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ..., 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease of injury in any way related to occupation of deceased?
If so, specify

(Signed) ..., M. D.

(Address)

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

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township — Primary Registration District No. 1002 — Registered No. 2445
City K. C. Mo (No. , St. Ward)

2. FULL NAME Mollie Wilson

(a) Residence, No. 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

3. SEX 7
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
46	8	6	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 6/14 1935 M. M. Crowe
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6 - 12 , 1935

22. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
I last saw h alive on , 19. Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

Intestional obstruction — Date of onset
acute peritonitis
caused by
Defect in the Mesentery
Tuberculosis

Other contributory causes of importance

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) A. G. Leitch , M. D.
(Address) Cor.

SUPPLEMENTARY

S-19802