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.

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

Do not use this space. 7.

SEP 29 1936

30859

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 3654
City Kansas City (No. St Joseph Hospital St. Ward)

2. FULL NAME Shepherd, Phyllis Rowena Tomlin
(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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) Jan. 21 - 1918
7. AGE YEARS 23 MONTHS 6 DAYS 15 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Salesgirl.
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) May - 1933
11. Total time (years) spent in this occupation 2

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

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

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

17. INFORMANT (ADDRESS) R. L. Halgard Parkville Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Parkville DATE Aug. 8 36
19. UNDERTAKER (ADDRESS) Leland K. Francis Parkville Mo
20. FILED Aug 7, 1936 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6, 1936

22. I HEREBY CERTIFY, That I attended deceased from 7/24, 1936, to 8/6, 1936
I last saw her alive on 8/6, 1936. Death is said to have occurred on the date stated above, at 3:35 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal Obstruction (Post operation)	10 days ago
Adhesions	
# Endometritis #	

35

Other contributory causes of importance:
Pulmonary Congestion
Lung abscess, Non T.B.

Name of operation Lap & Hysterectomy Date of 8/1/36 & 7/24/36
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? No 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 None
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) R. R. Hamilton, M. D.
(Address) St. Joseph Hosp. Mo.

This patient was operated May 11, 1932
--BILAT. SALPINGECTOMY
--APPENDECTOMY
Diag: Ac. Bilat. Salpingitis

Operated two years ago for uterine fixation operation

rated: 7-25-36--HERNIORRHAPHY (P.O.Hernia)
HYSTERECTOMY (Endometritis)
8-1-36 --RELEASE INTESTINAL OBSTRUCTION
(P.O.Intestinal Obstruction)

ase apparently gonococcal as history states that
atient received for treatment of gonorrhea during 9 months
revious to entry in July 1936.

(52) 30859

Aug 6, 1936

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.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 3654

City..... (No. St. Joseph's Hospital St. ..... Ward)

2. FULL NAME Rowena Tomlin

(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 FE

4. COLOR OR RACE

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

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

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

7. AGE YEARS 23 MONTHS DAYS If LESS than 1 day, ...hrs. or .....min.

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 Aug 7, 1936 M. M. Crowe
Registrar.

SUPPLEMENT

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6, 1936

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ..... 25 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:

Intes. Obstruction P.O.
Adhesions
P.O. Endometritis

Date of onset

Other contributory causes of importance:
Pulmonary congestion
Lung abscess

Name of operation Hysterectomy 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)....., M. D.

(Address).....