

MAR 13 1937

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Garrison
Kan
Kansas City

Registration District No.

Primary Registration District No.

(No.)

399
1002
K.C. Gen Hosp.

File No.

Registered No.

St.

Ward

6487

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

F.

W.

Widow

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. ormin.

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. UNDERTAKER (ADDRESS)

20. FILED

Sept 10 1875
62 61 5 3
None
Ohio
John W. Bryant
Ohio
Sarah Nance
Ohio
Debra Clark
Bury
2-16 1937
M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

1-29 1937 to 2-13 1937

I last saw her alive on 2-13 1937 Death is said

to have occurred on the date stated above, at 1:55 a.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Chronic vascular renal disease; Chronic Myocarditis and Nephritis

Other contributory causes of importance:

Tertiary Syphilis

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? no

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)

(Address)

, M. D.

R. F. De Marco
Sept 7 C Gen Hosp

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.

