

DEC 20 1937

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. 400
Township Prarie Primary Registration District No. 5553B
City County Hospital St. _____ Ward _____

File No. 41496
Registered No. 148

2. FULL NAME

(a) Residence, No. Little Blue River 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 9, 1937

5A. IF WIDOWED, OR DIVORCED OF Living

22. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1937, to Nov 9, 1937

I last saw her alive on 11-5, 1937 Death is said to have occurred on the date stated above, at 5:00 am.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31-1870

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 67 -2 -6

Chronic myocarditis (Date of onset)

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Homemaker

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.

Other contributory causes of importance:

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

13. NAME Postal weight

Name of operation _____ Date of _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

What test confirmed diagnosis? Chemical Was there an autopsy? No

15. MAIDEN NAME Unknown

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT Ernest Jackson

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Springs Mo DATE 11-8-37

Nature of injury _____

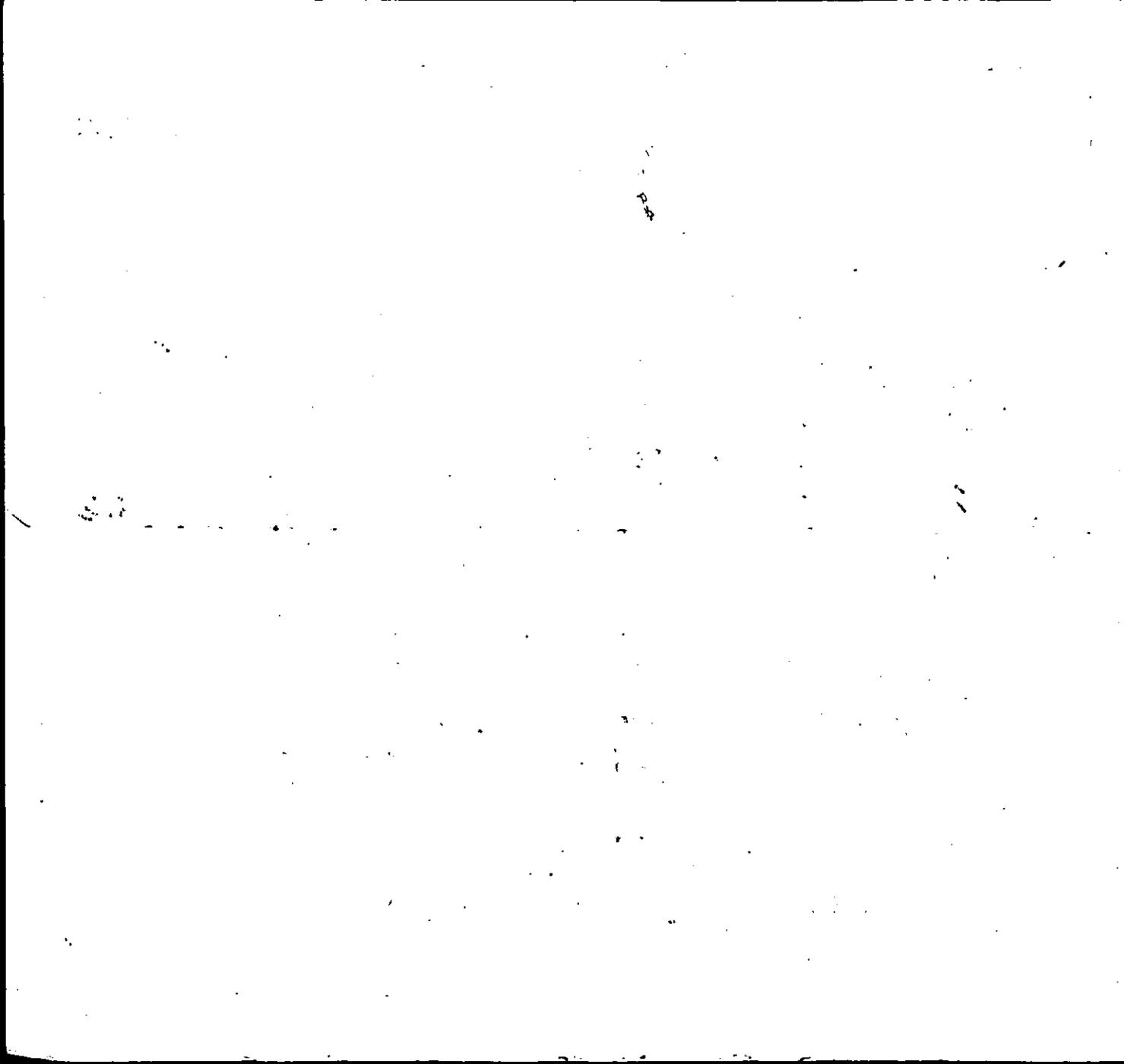
19. UNDERTAKER R. B. Webb

24. Was disease or injury in any way related to occupation of deceased? No

20. FILED Nov-10, 1937 William T. Fields Registrar

If so, specify _____ (Signed) J. H. Greene, M. D.
(Address) Independence

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

41496
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400
(b) Township Praine Primary Registration District No. 5-5-53 B Registered No. 103
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Elizabeth Gore St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
67 2 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Homemaker
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 24 38 William J. Fields Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 7 1930

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:

Date of onset

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 J. W. Greene, M. D.
(Signed) Independence
(Address) Ind

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

