

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

599
1002

1922
1739

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township 15am Primary Registration District No. _____
 City Kansas City Mo. (No. 3818 Genesee St. _____ Ward)

2. FULL NAME

Josephine E Raber
 (a) Residence No. 3818 Genesee St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 7 - 1854

7. AGE YEARS MONTHS DYS IF LESS than 1 day, _____ hrs. or _____ min.
67 | 8 | 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartford - Conn

10. NAME OF FATHER John Engler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) France

14. INFORMANT Charles Raber
 (Address) 3818 Genesee

15. FILED 4/17 1922 M. M. Crown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 - 1922

17. I HEREBY CERTIFY, That I attended deceased from April 12th 1922 to April 14th 1922 that I last saw h. as alive on April 14 1922, and that death occurred, on the date stated above, at 1215 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Hepatitis
124B
Severe (duration) _____ yrs. mos. da.

CONTRIBUTORY (SECONDARY) B (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

HAD AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHY TEST CONFIRMED DIAGNOSIS? none ✓

(Signed) J. C. Mason, M. D.

4/11, 1922 (Address) 3739 Genesee st

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Forest Hill Cemetery 4/17 1922
 20. UNDERTAKER ADDRESS

Colm W Wagner, 1409 Grand Ave

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.

