

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

Do not use this space.

8059

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 411 South Lawn) St. _____ Ward _____

2. FULL NAME Elizabeth Forsinger
 (a) Residence, No. 411 South Lawn 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. 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16, 1841

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	85	5	14	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (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) Ohio

10. NAME OF FATHER David Grove

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

12. MAIDEN NAME OF MOTHER Sarah Askew

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

14. INFORMANT Agnes Grove
 (Address) 1130 So. Pennsylvania
15. FILED 3/3 1927 M. M. Osburn
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1927, to March 2 1927
 that I last saw him alive on March 2 1927, and that death occurred, on the date stated above, at 8:30 A.

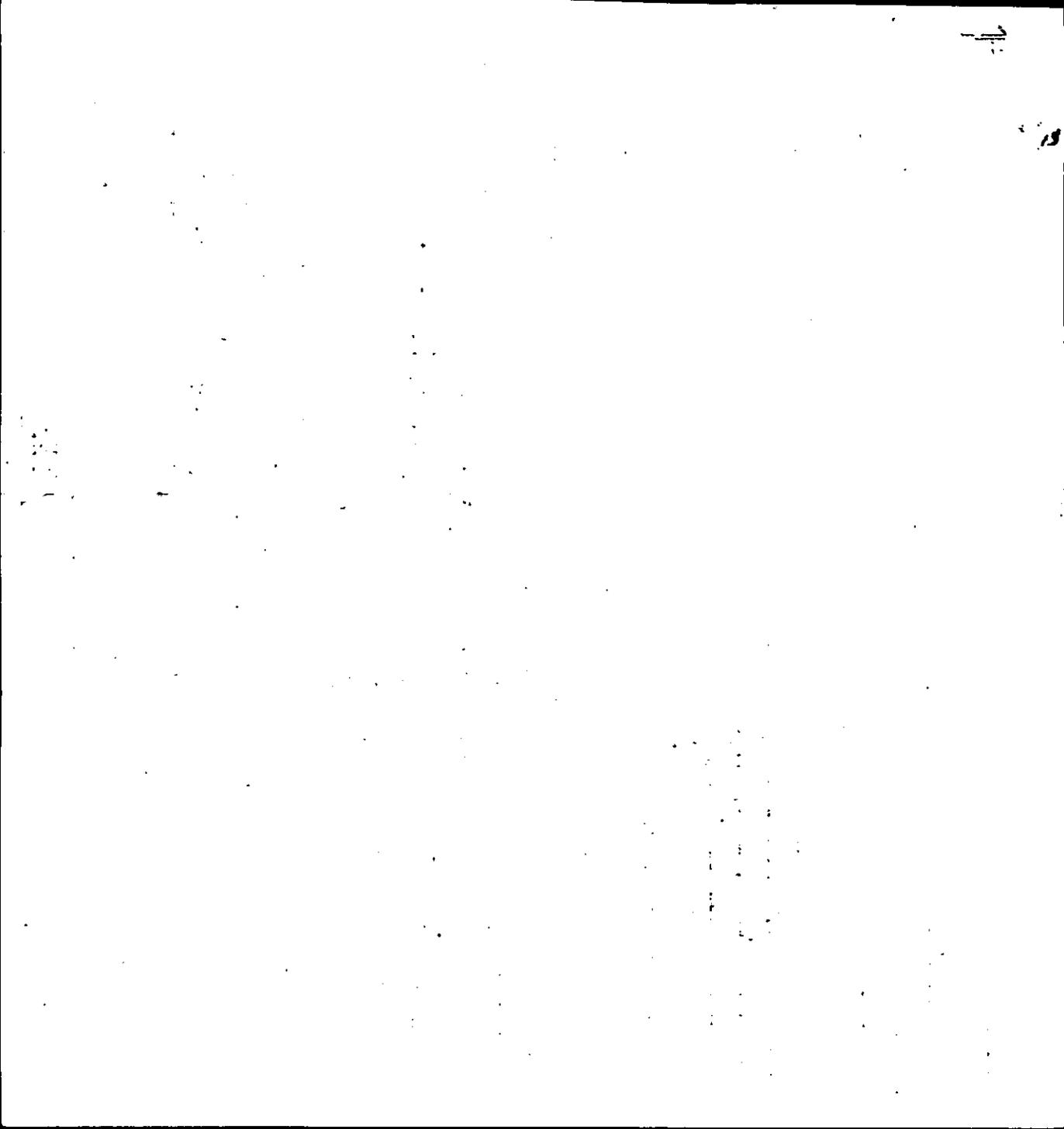
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acidosis, Nephritis
102
 (duration) yrs. mos. da. 4

CONTRIBUTORY (SECONDARY) Visceroptosis Scintilla
 (duration) 5 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY, _____
 WHAT TEST CONFIRMED DIAGNOSIS, _____
 (Signed) Frank W. Osburn, M.D.
3/3 1927 (Address) Ke Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Edenwood Cemetery DATE OF BURIAL 3-4-1927
20. UNDERTAKER Stone & M. Clure ADDRESS 924 Oak



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township _____ Primary Registration District No. 1002 Registered No. 909
 City Tan City (No. _____) St. _____ Ward _____

2. FULL NAME Elizabeth Forsinger
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 3/3, 1927 m m. Crivie REGISTRAR
adch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 2 1927

17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis & Hypertension
Non-diabetic

CONTRIBUTORY (SECONDARY) Thrombotic embolism (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. da.
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Arthur Weckhorst, M. D.
 , 19____ (Address) 734 Oregon Bldg

*State the DISEASE CAUSING DEATH, or in death 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

20. UNDERTAKER ADDRESS

MAINS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-8059