

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

Do not use this space.

8215

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township St. Louis Primary Registration District No. 3002 Registered No. 11119
 City Kansas City, Mo. No. 6130 Forest St. _____ Ward _____

2. FULL NAME Louise Lockhart
 (a) Residence. No. 6130 Forest St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
About 82

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (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) Indiana

10. NAME OF FATHER Mr. Weaver

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

12. MAIDEN NAME OF MOTHER Rebecca Schroeder 3-14-1917 (Address) 570 Athman Bldg

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

14. INFORMANT Jas. F. Lockhart
 (Address) 6130 Forest

15. FILED 3/14/27 Miss Brown
Asst-REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 13 1927

17. I HEREBY CERTIFY That I attended deceased from Dec 1st 1926, to March 13 1927 that I last saw h alive on March 13 20 P. 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

E. pneumonia of Lungs
936 (duration) yrs. mos. ds. 7
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 CONTRIBUTORY Chronic myocarditis
 (SECONDARY) (duration) yrs. mos. ds. 2

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Visual Examination
 (Signed) John T. Robinson M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL March 15 1927

20. UNDERTAKER St. Newcomer's Home ADDRESS R. 6, Mo.

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.

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Ver. 4060.

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