ST 24 1927

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

Do not use this space.

26502

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No.
Township — Primary Registration District No. 1001 — Registered No. 901
City St. Joseph, (No. Noyes Hospital St. Ward)

2. FULL NAME Agnes Mary Mayer
(a) Residence. No. 2407 So. 13th. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June, 14, 1905

7. AGE: Years 22 — Months 2 — Days 21 — If LESS than 1 day, ... hrs. or ..... min.

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) Leavenworth, Kansas

PARENTS
10. NAME OF FATHER Arthur T. Mayer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Easton, Mo. Ks.
12. MAIDEN NAME OF MOTHER Josephine Krank
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Leavenworth, Ks.

14. INFORMANT Arthur T. Mayer
(Address) 2407 So. 13th. St.

15. FILED SEP 7 1927 — John G. Wt — REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept, 5, 1927 19

17. I HEREBY CERTIFY, That I ~~attended~~ autopsied deceased ~~from~~ on Sep 5, 1927, to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11.00 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anaesthesia, suffocation from use of Ether
115A accidental,
178X (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes. DATE OF Sep 5/27
WAS THERE AN AUTOPSY? Yes.
WHAT TEST CONFIRMED DIAGNOSIS? Post Mortem finding + History of Symptoms
(Signed) J. W. Mays Coroner, M.D.
Sept. 6, 1927 (Address) St Joseph 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: Ashland Cemetery — DATE OF BURIAL: Sept, 7, 1927

20. UNDERTAKER: Walter Meierhoffer — ADDRESS: 1302 Faraon St.

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

cated by check marks, lacking from the death certificate: 901

Name: Agnes Mary Mayer

Who died at: St. Joseph Md. on Sept. 5. 1927.

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____ 181

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Anesthesia Suffocation from use of Ether - Accidental

Contributory: Hypertrophied tonsils

Where was disease contracted? _____

Did operation precede death? yes Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

S- 65502