

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

Do not use this space.

27188

1. PLACE OF DEATH

County Garrison Registration District No. 399 File No. _____
 Township Haw Primary Registration District No. 1002 Registered No. 31435
 City Kansas City (No. K.C. General Hosp) St. _____ Ward _____

2. FULL NAME

Rondelush Eugenia
 (a) Residence No. 3202 Wyoming 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. 3 mos. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-14-1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than day, _____ hrs. or _____ min.
	<u>3</u>		<u>105</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Roy Rondelush

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

12. MAIDEN NAME OF MOTHER Bethene Lawson

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

14. INFORMANT Reverend Clerk
 (Address) K.C. Gen'l Hosp.

15. FILED 9/7 1927 M. M. Brown REGISTRAR
accr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-4 1927

17. I HEREBY CERTIFY That I attended deceased from 9-4, 1927 to 9-4, 1927 that I last saw h. 2 alive on 9-4, 1927 and that death occurred, on the date stated above, at 3:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bilateral Lobar Pneumonia
108 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Acute Cardiac Failure (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 1010
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) George O. See, M. D.
9/6, 1927 (Address) General Hosp. K.C. Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Rehoboth No. 17 DATE OF BURIAL 9/7 1927

20. UNDERTAKER O. Mast ADDRESS 416 East 16

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.

PERMANENT RECORD

