

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

Do not use this space

30300

1. PLACE OF DEATH

County Jackson
Township Rau
City K.C. Mo.

Registration District No.
Primary Registration District No.

File No.
Registered No. 3805
St. Ward)

2. FULL NAME

Katie Srencker
(a) Residence. No. Wellington, Mo. St. 9 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 Fl 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 Chas. Srencker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-7-1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 | 1 | 1 | 2

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) Kansas

10. NAME OF FATHER

Jacob Reimich

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Ann Kuhn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill.

14.

INFORMANT Gertrude Murray
(Address) Wellington, Mo.

15.

FILED 10-8-27 M.M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1927

17. Deputy Coroner
I HEREBY CERTIFY, That I attended deceased from
19....., to 19.....

That I last saw h. alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of liver
(secondary)

52
4 to 6 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of skin
lower right arm
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) Stewart Garbough, M.D.

10/8, 1927 (Address) Deputy Coroner

*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

DATE OF BURIAL

Wellington, Mo. 10-8 1927

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster City

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.

DEPARTMENT RECORD

