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

Do not use this space.

36768

File No. 4584
Registered No.

1. PLACE OF DEATH

County: Jackson — Registration District No.
Township: Kaw — Primary Registration District No.
City: Kansas City (No. 3440 Campbell St. St. Ward)

2. FULL NAME Rosa L. Sebus

(a) Residence. No. 3440 Campbell St., 6 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 16, 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	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) Missouri

PARENTS
10. NAME OF FATHER John D. Pepper
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Martha J. Glover
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

14. INFORMANT Dora B. Merchant
(Address) 3440 Campbell

15. FILED 12-3, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1927, to Dec 2, 1927, that I last saw h. alive on Dec 2, 1927, and that death occurred, on the date stated above, at 4:55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Stenosis & Insufficiency
JCW
(duration) many yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Decompensation
(duration) yrs. 4 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? no
What test confirmed diagnosis? symptoms
(Signed) R. T. Sloan, M. D.
12-3, 1927 (Address) Ridge Bldg

*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: Westons Mo. — DATE OF BURIAL: 12/3 1920

20. UNDERTAKER: Stine & McClure — ADDRESS: 924 Oak

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 INKING INK—THIS IS A PERMANENT RECORD

Dr. R. T. Sloan
1125 Rialto Bldg.
1-4 P. M.