

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

Do not use this space.

1029

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 20  
 Township Tau Primary Registration District No. 1002 Registered No. 20  
 City Kansas City (No. St. Joseph's Hosp. St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Mrs. Anna Hebler  
 (a) Residence. No. 85th + Shouten St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 12, 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
51 9 24

**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) Maine

**10. NAME OF FATHER**

Adam Young

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Maine

**12. MAIDEN NAME OF MOTHER**

Rose Brown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Maine

**14.**

INFORMANT Fred O. Hebler  
 (Address) 85th + Shouten

**15.**

28 M. M. Crowe  
 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 19 28

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1927 to Jan 6, 1928, that I last saw her alive on Jan 6, 1928, and that death occurred, on the date stated above at 1:41 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septicemia  
 (duration) \_\_\_\_\_ yrs. mos. da.  
 CONTRIBUTORY Obesity in Segment  
following (duration) \_\_\_\_\_ yrs. mos. da.  
following

**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**

(Signed) John O. Shryver, M. D.  
 (Address) 844 Lathrop 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**

Forest Hill DATE OF BURIAL Jan 7 19 28

**20. UNDERTAKER**

L. H. Newcomer's Sons & Co. ADDRESS \_\_\_\_\_

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

ORIGINAL RECORD

844 Latropt

Vic. 7010.

1-5:30

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson Registration District No. 399

File No. ....

Township .....

Primary Registration District No. 10021

Registered No. 49

City Wassau (No. St. Joseph Hosp.)

St. Joseph Hosp. St. .... Ward)

2. FULL NAME Mrs. Anna Hebler

(a) Residence. No. .... 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

16, 1928 M. M. Crowe  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1928

17. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19..... that I last saw him ..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septicemia  
..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY abscess in sigmoid  
(SECONDARY) following Colostomy  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED Colostomy done about 5 years ago  
IF NOT AT PLACE OF DEATH, for stricture of rectum following  
HAD AN OPERATION PRECEDE DEATH? rectal abscess DATE OF .....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19. PLACE OF BURIAL, CREMATION, OR REMOVAL 1199 DATE OF BURIAL

\*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

20. UNDERTAKER

ADDRESS

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

Vital information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-1029