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

Do not use this space.

1391

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 415

Township Kaw — Primary Registration District No. 1002 — Registered No. F

City Kansas City Mo (No. 2929 Main — Willow Willows Hosp — Ward

2. FULL NAME Irena Belle Buchanan

(a) Residence. No. Turner Kans. St. Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 12 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	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13, 1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	18	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work clerking
(b) General nature of industry, business, or establishment in which employed (or employer) Department Store
(c) Name of employer Jones Store

9. BIRTHPLACE (CITY OR TOWN) Turner
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER George Alesworth Buchanan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) New York
12. MAIDEN NAME OF MOTHER Anna Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) Illinois

14. INFORMANT Au Kinsey RN
(Address) 2929 Main St.

15. FILED Jan 30 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1928

17. I HEREBY CERTIFY, That I attended deceased from 9 A.M. to 940 P., 19 Jan 27 — 1928, that I last saw her alive on Jan 27 — 1928, and that death occurred, on the date stated above, at 940 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
#148 International list
141
111B
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Edema of lungs
(duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Jno W. Kepner, M. D
1-27, 1928 (Address) 2929 Main St. K.C. 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: Stanley Kansas — DATE OF BURIAL: Jan 30 1928

20. UNDERTAKER: Simmons & Son — ADDRESS: K.C. Ks

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH.

County ..... Registration District No. 399 ..... File No. .....

Township ..... Primary Registration District No. 1002 ..... Registered No. 415

City K. C. ..... (No. ..... St. ..... Ward)

2. FULL NAME Irena Belle Buchanan

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	D

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)

PARENTS

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 Jan 30, 1928 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1928

17. 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:

~~#148~~

#148 - (No convulsions)

(Puerperal albuminuria) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Edema of lungs

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Jno W Kepner, M. D

4/7, 1928 (Address) 2929 Main St.

148

*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 19
20. UNDERTAKER	ADDRESS

...XACTLY. PHYSICIANS should state ...nt of OCCUPATION is very important.

...RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-1391