

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

Do not use this space.

9175

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Knox Primary Registration District No. 1007
 City Kansas City, Mo. (No. Mersey Hospital) St. _____ Ward _____

File No. _____
 Registered No. 1035
 St. _____ Ward _____

2. FULL NAME Lola Kibler
 (a) Residence. No. 1033 Brooklyn St. Q 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 F. **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Child
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-11-1912

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, _____ hrs. or _____ min.**
15 6 15

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Child
 (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) Ill

10. NAME OF FATHER William Kibler

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

12. MAIDEN NAME OF MOTHER Vallie Garrison

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

14. INFORMANT (Address) Mrs Vallie J Kibler
1033 Brooklyn

15. Filed 3/26, 1928 M. M. Osawe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March-16-1928

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1928, to March 26, 1928
 that I last saw h.e.r. alive on March 25, 1928, and that death occurred, on the date stated above, at 4:30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
5 fluro-myelogenous
10 P. Leukemia
73 P. " " " (duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Post-operative shock (duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED at home.
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF March 24

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation + Laboratory
 (Signed) Charles Jeldredge, M. D.
3-26, 1928 (Address) 791 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 Mt Washington **DATE OF BURIAL** 3/28 1928

20. UNDERTAKER Mrs C. F. Forster ADDRESS KC, Mo

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Lawn Primary Registration District No. _____ Registered No. 1355
 City Keosauqua (No. Therapy Hosp) St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1033 Brooklyn St., _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 15

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) _____

INFORMANT _____
 (Address) _____

FILED 3/26 29 M. M. Crowe REGISTRAR
Am

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 26 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Splenic myelogenous leukemia

CONTRIBUTORY (SECONDARY) Post Operative splenectomy (duration) 3 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3. 24. 28
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Charles J. Eldredge, M. D.
June 6, 1928 (Address) 716 Rathway 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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

C. R. 1

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