

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

Do not use this space.

13225

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township St. Mary Primary Registration District No. 1002  
 City Kansas City (No. 2437) Quincy St. 14 Ward

File No. 1555  
 Registered No. 1555

**2. FULL NAME**

Mrs Anna R Monod  
 (a) Residence. No. 2437 Quincy St., 14 Ward.  
 (Usual place of abode)

Length of residence in city or town where death occurred 15 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) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 26, 1837

7. AGE: YEARS 89 MONTHS 4 DAYS 9 If LESS than 1 day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN) Switzerland  
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Meiller

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

12. MAIDEN NAME OF MOTHER Rens

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

14. INFORMANT John L. Monod  
 (Address) 2437 Quincy

15. FILED 4/5 28 M. M. Coe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5 1928

17. I HEREBY CERTIFY, That I attended deceased from 9:15 22 1928, to April 5 1928 that I last saw him alive on April 4, 1928, and that death occurred, on the date stated above, at 7:30 a. m.

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

Fracture of Hip  
 (duration) 1 mo. 15 ds.

CONTRIBUTORY Arterio Sclerosis  
 (SECONDARY) (duration) 10 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) R. L. St. Clair, M. D.

4/5, 1928 (Address) 5242 St. John  
 \*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 Stella, Nebr. DATE OF BURIAL Apr. 6 1928

20. UNDERTAKER H. H. Newcomer's Sons ADDRESS N.C.M.

K. 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.

PERMANENT RECORD

92426  
A

noted  
date

2130-5  
1018.6

10  
10

2130-5  
1018.6

**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.....

Registration District No. 399

File No. ....

Township.....

Primary Registration District No. 1002

Registered No. 13-5-5-

City Kans City (No. ....) St. .... Ward)

**2. FULL NAME** Mrs Anna O. Monod

(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*) .....

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 45 19 28 M. M. Browe REGISTRAR  
Dean

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 5 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:

fracture of hip  
fallen on floor, accidental

CONTRIBUTORY (SECONDARY) Arterio sclerosis (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) M. L. Clark, M. D.

, 19 (Address) 5242 St. John

\*State the DISEASE CAUSING DEATH, or in death 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

PERMANENT RECORD

Every item of information should be given EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important.

AGE should be supplied. AGE at DEATH in plain terms, so that it may be properly classified

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENT

185

5-17-92