

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

Do not use this space.

17219

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Haw Primary Registration District No. 1002
 City Kansas City (No. 53rd. Highland) St. _____ Ward _____

File No. _____
 Registered No. 91

2. FULL NAME

Mrs. Rose Conrad
 (a) Residence. No. 53rd. Highland St. _____ Ward _____
 (Usual place of abode) Home of the aged (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. 15 How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Chas Conrad</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unk 1841</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>87</u>			
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (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) Prussia

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not known

14. INFORMANT Sister Marie Auguste
 (Address) 53rd. Highland Little Sisters of the Poor

15. FILED 5/18/28 M. M. Croove
 REGISTRAR Cross

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and 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:
Chronic Myocardial 53E
49
49 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTOR(S) (SECONDARY) Paralysis of left shoulder (duration) _____ yrs. _____ 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? Postmortem History
 (Signed) Paul Garbough M. D.
5/16, 1928 (Address) Deputy Coroner

*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 Heavenworth Kansas DATE OF BURIAL 5/18/28

20. UNDERTAKER Lusk, Robin - 203 West Lenwood ADDRESS _____

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.

DEPARTMENT RECORD

