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

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 23815
Township Kaw — Primary Registration District No. 1002 — Registered No. 2941
City Kansas City Mo (No. 2929, Main St. ~~Ward~~)

2. FULL NAME Maxine Guest Willows Hopt
(a) Residence. No. 2929 Main 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. 4 mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10, 1925

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, — hrs. or — min.
22	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: clerk in Grocery
(b) General nature of industry, business, or establishment in which employed (or employer): A + P chain Store
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Milledgeville
(STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER Jesse Guest
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Milledgeville
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Dora Bugher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sterling
(STATE OR COUNTRY) Illinois

14. INFORMANT Alice U Kinsey R.N.
(Address) 2929 Main St.

15. July 8th 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 29, 1928, to July 8, 1928 that I last saw h.c.x. alive on July 8, 1928, and that death occurred, on the date stated above, at 10.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
No. 146 International List
145 A
(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (SECONDARY) Pelvic abscess —
24 days or more (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? Rupture of abscess
(Signed) Jno W. Kepner, M. D
7/8/, 1928 (Address) 2929 main

*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: Lanark Ill
DATE OF BURIAL: 7/8 1928

20. UNDERTAKER: Eylars Bros.
ADDRESS:

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. 2941

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

2. FULL NAME Maxine Guest

(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	S

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

...PLACE OF MOTHER (CITY OR TOWN) .....
...E OR COUNTRY)

...RMANT .....
...ddress)

...ED 7/8 19 28 M M. Crowe
Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 19 28

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:
No. 146 Puerperal Septicemia

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

CONTRIBUTORY (SECONDARY) Pelvic abscess

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

146

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) Geo W Kepner, M. D

8-25-, 1928 (Address) 2929 Main St.

*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

...LL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23815