

GAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

D. J. Walsh
835 G. St.

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

Do not use this space.

33686

1. PLACE OF DEATH *124*

County *Jackson*
Township *Kaw*
City *Kansas City*

Registration District No. *399*
Primary Registration District No. *1002*

File No. _____
Registered No. *226*
St. _____ Ward _____

2. FULL NAME *Mrs. Mary Mercier*

(a) Residence. No. *5624 Park* St. *15* Ward. _____
(Usual place of abode)

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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Vincent J Mercier*

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *At Home*
(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) *Missouri*

PARENTS

10. NAME OF FATHER *Henry Redfern*

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 *Vincent Mercier*
(Address) *5624 Park*

15. FILED *10/17/28* *M. M. Browne*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from *10-15*, 19*28*, to *10-16*, 19*28*, that I last saw *her* alive on *10-15*, 19*28*, and that death occurred, on the date stated above, at *7:30 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ethelionema of pneumonia

53E

CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *10-15-28*

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*
(Signed) *A. J. Walsh*, M. D.

10/17, 19*28* (Address) *835 G. 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

Mrs St Marye *10/18/28*
20. UNDERTAKER ADDRESS

Quirk & Tobin Co--20 W Linwood

D. 9
A. 1

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

**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.....
Township.....
City *K. City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *4226*
St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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 *10/17* 19 *28* *M. M. Crowe* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 16* 19 *28*

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Epithelioma of spinal cord

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: *St. Joseph Hospital*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *microscope*

(Signed) *R. Welch* M. D.

, 19 (Address)

*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

WRITE IN INK. THIS IS A PERMANENT RECORD.
 N. S. B. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 REC. NOT RECEIVED A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

