

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

Do not use this space.

36894

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Leaw Primary Registration District No. _____
 City Kansas City (No. 72C General Hosp. St. _____ Ward)

File No. 41123
 Registered No. _____

2. FULL NAME

Schmidt Mary
 (a) Residence. No. 1020 Tracy St. 2 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 1 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct. 11, 1928</u>		
7. AGE	YEARS	MONTHS
		<u>0</u>
		<u>28</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Child</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9 1928

17. I HEREBY CERTIFY, That I attended deceased from 11-9 1928 to 11-9 1928 that I last saw her alive on 11-9 1928, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute manitonia
158 / 60 (duration) yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? Blood transfusion

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF 11-9-28
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chem Fund.
 (Signed) P. E. Wellcup, M. D.
11-9 1928 (Address) Supt 72C Gen Hosp

*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.

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Geo Schmidt

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT Record Clerk
 (Address) 72C Genl Hosp

15. FILED 11-10-28 MM Crowl
 REGISTRAR ast

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill Cemetery DATE OF BURIAL 11-9 1928

20. UNDERTAKER Geo. P. Schmidt ADDRESS D. W. Newsome and Co 72C Mo

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SECRET

**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 H. City.....
City H. City No.....

Registration District No. 399
Primary Registration District No. 1002

File No. 4543
Registered No.
St. Ward)

2. FULL NAME Schmidt Mary

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (use 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 Unknown

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

14.

INFORMANT (Address)

15.

FILED 11-10-1928 M. M. Casner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-1928

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:

CONTRIBUTORY (SECONDARY) (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. 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

19

20. UNDERTAKER

ADDRESS

PERMANENT RECORD

ONLY WITH UNFADING INK

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.

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

SUPPLEMENTARY

S-36894