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

Do not use this space.

399

1002

40585

File No. .....

Registered No. 40585

1. PLACE OF DEATH

County Jackson

Township Kaw

City Kansas City Mo (No.) 2413 East 23 St. ..... Ward)

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME George F. Schlosser

(a) Residence. No. 2413 E. 23 St., 11 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: Male

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 27 1858

7. AGE: Years 70 | Months 10 | 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) Farmer

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY) New York

PARENTS

10. NAME OF FATHER Christ Schlosser

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Catherine Seitz

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

(STATE OR COUNTRY) Germany

14. INFORMANT Mrs Annie M. Schlosser

(Address) 2413 East 23

15. FILED 12/7, 1928 M. M. Crane Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-6 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1928, to Dec 6, 1928, that I last saw him alive on Dec 6, 1928, and that death occurred, on the date stated above, at 3:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

9 SB

10 PA

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Organic heart trouble (duration) 5 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? Complete Blocking

(Signed) J. Lungs D. L. Foster, M. D.

(Address) 4022½ Prospect

*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 La Harpe Ks

DATE OF BURIAL 12/8 1928

20. UNDERTAKER Oll Hall

ADDRESS 1916 Cass

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD