

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

Do not use this space.

40835

1. PLACE OF DEATH

County Jackson
Towship Frank
City Kansas City

Registration District No. 399

File No. 3211
Registered No. 3211
St. _____ Ward _____

2. FULL NAME Shapel Marion

(a) Residence. No. 3549 Brighton St., 14 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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)

4-6-1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

1

8

10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Student

(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) 12-16-1928

17.

I HEREBY CERTIFY, That I attended deceased from 12-13-1928, to 12-16-1928

that I last saw her alive on 12-16-1928, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brucella pneumoniae
1074
8913

(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ da.

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) J. J. Jewett, M.D., M. D.

12-16-1928 (Address) Dist. Supt., K.C.D.H.

*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, Missouri

(STATE OR COUNTRY)

10. NAME OF FATHER

Harold Shapel

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas

12. MAIDEN NAME OF MOTHER

Kind Book

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14. INFORMANT

Records Clerk
Kansas City Gen. Hosp.

15. FILED

12/17/28
M. M. Crowe
Ass. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Washington 12-18-28

20. UNDERTAKER

ADDRESS

1916 Criss

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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..... Registration District No. 399 File No.....
 Township H. City Primary Registration District No. 1002 Registered No. 5211
 City H. City (No.) St. Ward

2. FULL NAME

Marian Shaper
 (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

MEDICAL CERTIFICATE OF DEATH

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

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

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

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.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Bacterial pneumonia

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

CONTRIBUTORY (SECONDARY) Acute Otitis Media
 (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH?..... DATE.....

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

12. MAIDEN NAME OF MOTHER

20. UNDERTAKER ADDRESS

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

(Signed)..... M. D. , 19 (Address)

14. INFORMANT (Address) 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 12/17 19. 28 M. M. Conroy REGISTRAR Asst

SUPPLEMENTARY

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

CAUSE OF DEATH in plain terms, so far as it may be ascertained.

S410835

1928