

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

Do not use this space.
40966

3347

1. PLACE OF DEATH

County Jackson
Township St. Paul
City Kansas City

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

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. 3742 Penn St. 5 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 27 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 | 2 | 23

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) Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Albert Peter

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

12. MAIDEN NAME OF MOTHER Josephine

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) no record
(STATE OR COUNTRY)

14. INFORMANT Frank Fowler
(Address) H637 E 9

15. FILED 12-22 1928 REGISTRAR mmg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1928 to Dec 20 1928 that I last saw h. alive on 8-4-28 and that death occurred, on the date stated above, at 8:48 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Lobar

100 / 1065 / 10
..... (duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) Chronic bronchitis
..... (duration) yrs. mos. ds. 2/da

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) J. W. Robertson, M. D.
(Address) K.C. Mo

*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 Elmwood DATE OF BURIAL Dec 21 1928

20. UNDERTAKER Mrs. G. L. Farster ADDRESS K.C. Mo.

WRITE PLAINLY, 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.

12th & Broadway

ap. 8866

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