

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.

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

Do not use this space.

1498

1. PLACE OF DEATH
County Jackson

Township Kaw

City Kansas City

Registration District No. 399

Primary Registration District No. 1002

(No. 3926 Wyoming)

File No. _____

Registered No. 85

St. _____ Ward _____

2. FULL NAME Mary G. Brant

(a) Residence. No. 3926 Wyoming

(Usual place of abode)

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

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

Adam Brant

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

Nov. 12 .1856.

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1

day, _____ hrs.

or _____ min.

72.

1

26

8. OCCUPATION OF DECEASED

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

Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

11

(c) Name of employer

11

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana.

10. NAME OF FATHER

Wm. J. Gregory

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.A.

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.A.

14.

INFORMANT

Adam Brant

(Address)

3926 Wyoming St

15.

FILED

Jan 8, 1929 M. M. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 8 1929

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

1:10

death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131

932

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

CONTRIBUTORY (SECONDARY)

Chronic valvular
refractor.

(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)

Stanley M. Hall

M. D.

1/8

1929 (Address)

Deputy Coroner

*State the DISEASE CAUSING DEATH, or if 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

Bedford Iowa.

1/10/ 1929

20. UNDERTAKER

ADDRESS

H.W.Gates

K.C.Ks.

