

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

Do not use this space.

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6735

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kau Primary Registration District No. 1002
 City Kansas City (No. 2407 Linwood Blvd) St. _____ Ward _____

2. FULL NAME Mrs. Eva Showalter
 (a) Residence, No. 2407 Linwood Blvd St. 13 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF C.M.C. Showalter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 6, 1859

7. AGE YEARS 70 MONTHS 1 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.

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) _____ (STATE OR COUNTRY) Illinois

10. NAME OF FATHER J. A. Pasy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Mary Ann Whitely

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

14. INFORMANT C.M.C. Showalter
 (Address) 2407 Linwood Blvd

15. FILED 2/23/25 M. M. Conne
East REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 23 1929

17. I HEREBY CERTIFY That I attended deceased from July 7 - 1928 to Feb. 23 - 1929 that I last saw him alive on Feb 22 - 1929, and that death occurred, on the date stated above, at 4:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
B2A
97 apoplexy
arterio-sclerosis (duration) yrs. mos. 3 ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chemical and Lab.
 (Signed) D. W. Martin, M. D.
23 19 29 Address 6800 Wash Ph Blvd

*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 Gaffney, Mo. DATE OF BURIAL Feb. 24 1929

20. UNDERTAKER Freeman Mortuary ADDRESS 194 W. 13th St.

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Dr. J. W. Martin.
6800 Washington Ch Blvd
SE 6232

**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..... Primary Registration District No. 1002 Registered No. 901
 City City (No.....) St..... Ward.....

2. FULL NAME Mrs Eva Showalter

(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 (*write the word*) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 6 - 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
70 10 17

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)

PARENTS
 10. NAME OF FATHER.....
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY).....
 12. MAIDEN NAME OF MOTHER.....
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY).....

14. INFORMANT..... (Address).....

15. FILED 2/23, 29 Tn. M. Browne REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1929

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:

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFIED COPIES

SUPPLEMENTARY

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