

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

Use this space.
6825
File No. **991**
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Law Primary Registration District No. 1002
City Kansas City (No. 5118) Forest

2. FULL NAME

Mrs. Martha A. Loewer
(a) Residence. No. 5118 St. _____ Ward. Sedalia Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>59</u>	<u>11</u>	<u>21</u>	

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).
(c) Name of employer

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

10. NAME OF FATHER Lewis Yunker

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

12. MAIDEN NAME OF MOTHER Schmidt

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

14. INFORMANT Albert J. Loewer
(Address) Sedalia Mo

15. FILED 2/28 1929 M. M. Crow
Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 27 1929

17. I HEREBY CERTIFY, That I attended deceased from 2/26, 1929, to 2/27, 1929, that I last saw him alive on 2/27/29, 1929, and that death occurred, on the date stated above, at 6 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
314 7401
97 (duration) yrs. mos. ds.
CONTRIBUTORY arteriosclerosis,
(SECONDARY)
hypertensia (duration) 6 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? Physical findings

(Signed) D. C. Coffey, M. D.

2/28, 1929 (Address) 238 Argyle Bldg, 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 Mt. Moriah DATE OF BURIAL Mch. 1 1929

20. UNDERTAKER D. W. Newcome's Sons ADDRESS 2111 E 9th St N.E. Mo.

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

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10

