

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

Do not use this space.

6829

**1. PLACE OF DEATH**

County.....Jackson.....  
Township.....Kaw.....  
City.....Kansas City..... (No. 835 West 39th St.)

Registration District No. 1002  
Primary Registration District No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 995  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mrs. Isabella Munro

(a) Residence. No. 835 West 39th Street St. 7 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**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Widowed

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

Alex Munro

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** June 7-1855

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>73</u>	<u>8</u>	<u>19</u>	

**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) Scotland

**10. NAME OF FATHER** Alex McKenzie

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

**12. MAIDEN NAME OF MOTHER** Elizabeth McKenzie

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

**14. INFORMANT** Mary E. Munro  
(Address) 835 W 39th St. Kansas City

**15. FILED** Apr 29 1929 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Febr 26 1929

**17. (Had rem patient 2 years ago - stroke)**  
I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_

that I last saw her alive on Febr 26 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Cerebral Embolism

92 H  
82 B

**CONTRIBUTORY (SECONDARY)** Myocardial Regurgitation  
(duration) 2 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_**  
**20. WAS THERE AN AUTOPSY? \_\_\_\_\_**  
**WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_**

(Signed) E. H. Feilinger, M. D.  
427 1929 (Address) H. 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 Washington **DATE OF BURIAL** Febr 25 1929

**20. UNDERTAKER** R. F. Lindley, Deary, City  
**ADDRESS** \_\_\_\_\_

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.

235  
8  
8  
8

10-10-10