

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

Do not use this space.

10576

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 4500 Charlotte St. St. _____ Ward _____)

File No. _____
 Registered No. 10578
 St. _____ Ward _____

2. FULL NAME Mrs. Katharine Wright Haskell

(a) Residence No. 4500 Charlotte St. St. _____ Ward _____ (If nonresident, give city or town and State)
 (Usual place of abode)

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** married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 19, 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	54	6	14	

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) Dayton
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Milton Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rush Co.
 (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Susan Catherine Koerne

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Loudin Co.
 (STATE OR COUNTRY) Virginia

14. INFORMANT Lorin Wright
 (Address) 1606 Grandbluffs

15. FILED 3/4, 1929 Dayton, Ohio
W. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from February 21, 1929, to March 3, 1929
 that I last saw her alive on March 3, 1929, and that death occurred, on the date stated above, at 8:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia
1000 (duration) yrs. mos. ds. 10

CONTRIBUTORY (SECONDARY) bronchitis
 (duration) yrs. mos. ds. 7

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) R. T. Terhan, M. D.

3/4, 1929 (Address) Med Park 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 Dayton, Ohio **DATE OF BURIAL** 3-4 1929

20. UNDERTAKER Stine + McPurre **ADDRESS** 3235 Hillman
U.S.O. Delaga.

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.

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