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

Do not use this space.

File No. 10643
Registered No. 1140

Registration District No. 399
Primary Registration District No. 1002

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City Mo (No. Research Hosp St. Ward)

2. FULL NAME: Marienne Overall
(a) Residence. No. 3862 Charlotte St., 6 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wilson L Overall

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 5 1890

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
38	11	1	

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): Kansas City Mo

PARENTS
10. NAME OF FATHER: Leon T. Brown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Steubenville N.Y.
12. MAIDEN NAME OF MOTHER: Mary Mc Hovey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Independence do

14. INFORMANT: Wilson L Overall
(Address): 3862 Charlotte St

15. FILED 3/7, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 6 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-23, 1929, to 3-6, 1929 that I last saw h alive on 3-6, 1929 and that death occurred, on the date stated above, at 10:35 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Gangrenous Appendicitis, Ruptured
(duration) yrs. mos. 11 ds.
CONTRIBUTORY (SECONDARY): Pneumonitis
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED: At Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-2-29
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Gross Exam
(Signed) D. L. Myers M. D.
3/7, 1929 (Address) 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: Forest Hill Cemetery
DATE OF BURIAL: March 9 1929
20. UNDERTAKER: John F Wagner
ADDRESS: 1409 Grand Ave

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