

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City Kansas City (No. Trinity Lutheran Hosp)

Registration District No. 399  
Primary Registration District No. 1002

18421  
File No. 2160  
Registered No. 2160  
Ward

**2. FULL NAME**

(a) Residence. No. Appleton City, Mo. St., Mo. Ward.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. 6 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) un

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
about 50

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housekeeping  
(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) Missouri

**10. NAME OF FATHER**

Unknown

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) unk

**12. MAIDEN NAME OF MOTHER**

unk

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) unk

**14. INFORMANT**

(Address) James O Ginter  
Appleton City Mo.

**15. FILED**

5/31 1929 M. M. Crowe  
REGISTRAR

**4 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1929

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929 to May 31, 1929 and that I last saw her alive on May 30, 1929 and that death occurred, on the date stated above, at 3:40 a.m.

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

Obesity  
Chronic Interstitial  
131 Nephritis  
936 (duration) 18 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Chronic Myocarditis  
100 - Cordiae (duration) 6 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED?**

Home

**IF NOT AT PLACE OF DEATH**

DID AN OPERATION PRECEDE DEATH? No DATE OF

**19. WAS THERE AN AUTOPSY?**

Yes

**WHAT TEST CONFIRMED DIAGNOSIS?**

Clinical & Autopsy

(Signed) John H. Ogilvie M. D.

Address 1002 Argyle

\*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**

Appleton City Mo June 7 1929

**20. UNDERTAKER**

**ADDRESS**

Frank Lee Appleton City Mo

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.

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