

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

Do not use this space.

21653
2793

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 4123 Park St. _____ Ward)

2. FULL NAME Marie Louise Lantry

(a) Residence. No. 4123 Park St. 15 Ward. (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 Sperry Lantry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 0 25

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) IOWA

PARENTS

10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT Sperry Lantry
(Address) 4123 Park

15. FILED 6/25 29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24, 1929

I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 23, 1929 that I last saw her alive on June 22, 1929 and that death occurred, on the date stated above, at 3:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Embolism

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Unknown Infection
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

17. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. H. M. Smith M. D.

June 24 1929 (Address) 505 5th Ave Supt

*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

Mount Washington Cem 6-25 1929

20. UNDERTAKER ADDRESS

Stine & McClure 3235 Millham
Flaga

No. 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.

RECORDING INFORMATION—THIS IS A PERMANENT RECORD

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Dr. Robert Smith,
505 Grand Avenue Temple
VI-8933

Hours

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