

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

Do not use this space.

24796
3208

1. PLACE OF DEATH

County Jackson
Township Rau
City Kansas City (No. General Hospital)

Registration District No. 399
Primary Registration District No. 1902

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Seemfu Martin
(a) Residence. No. 5129 Wayne St., 15 Ward.

(Usual place of abode) _____ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 30-1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>77</u>	<u>6</u>	<u>24</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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) Ohio

10. NAME OF FATHER

Walter Seemfu

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14.

INFORMANT Record Clerk
(Address) K.C. Deil Hoop

15.

FILED 7/25/29 M.M. Crow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-24 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-24, 1929, to 7-24, 1929, that I last saw h. un alive on 7-24, 1929, and that death occurred, on the date stated above, at 6:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

5 angrenous, bacterial
with Pyonephrosis
930

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Chronic myocarditis
(SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. E. Williams, M. D.

7/25, 1929 (Address) K.C. Deil Hoop

*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

Christine Cemetery July 26 1929

20. UNDERTAKER

2512 Halsted

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

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10
31

