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

Do not use this space. 27816 3508

1. PLACE OF DEATH
County Jackson — Registration District No. 1002 — File No.
Township Kaw — Primary Registration District No. — Registered No.
City Kansas City Mo (No. St Marys Hos St. Ward)

2. FULL NAME Conrad Mall
(a) Residence. No. 2112 Charlotte St., 3 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Fredricka Mall
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 15 - 1929
7. AGE: 82 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(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): Germany
PARENTS
10. NAME OF FATHER: Mall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
14. INFORMANT: Geo W Mall
(Address) 2112 Charlotte St
15. FILED 8/16, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 15 — 1929
17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Aug 15, 1929 that I last saw him alive on Aug 15, 1929, and that death occurred, on the date stated above, at 5 P. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute uremic poison (duration) yrs. mos. 6 ds.
CONTRIBUTORY (SECONDARY): suppression of urine (duration) yrs. mos. 10 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 13-1929
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) S B Prentiss, M. D.
8/16, 1929 (Address) 1215 Realty Bldg.

*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: Aug 1929
20. UNDERTAKER: John W Wagner - 1409 — ADDRESS: Grand Ave

N. B.— ...should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ...forms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible]

[illegible] to that it may be properly c[illegible]ded. Ka[illegible] statement of JCC [illegible]

[illegible]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 7508
City K C Mo (No. St. Marys Hospital St. Ward)

2. FULL NAME Conrad Mall

(a) Residence. No. St., 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
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 6, 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	11	9	

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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 8/16, 19 21 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-15-1929

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19, that I last saw h. alive on , 19, and that death occurred, on the date stated above at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ac. uremic Poison
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Suppression of urine
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Per was done to drain bladder, relieve retention of urine
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8/13/29
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRAR — CAUSE OF DEATH in ... — N. B.—Every item of information ... FEL FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW — ... operly classified. Exact statement of OCCUPATION is very ... tant.

5-37816