

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

Do not use this space. 27886

3578

1. PLACE OF DEATH **399**
 County Jackson Registration District No. 002
 Township Law Primary Registration District No. 002
 City Kansas City (No. St. Lukes Hosp) St. _____ Ward _____
 2. FULL NAME Norothy E. Levey
 (a) Residence, No. 44211 Main 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. 2 mos. ds. 7 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 Abraham H. Levey
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 9 1911
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
18 7 12
 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) Oklahoma
 10. NAME OF FATHER James H. Chamber
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Idaho
 12. MAIDEN NAME OF MOTHER Elizabeth Ray
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Idaho

14. INFORMANT Lucille E. Dorner
 (Address) 6154 Kenwood
 15. FILED 8/22 19 29 M. M. Crowe REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 21 19 29
 17. I HEREBY CERTIFY, That I attended deceased from July 16, 1929 to Aug 20, 1929 that I last saw h. alive on Aug 20, 1929, and that death occurred, on the date stated above, at 6:30 A. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial pneumonia
Brain Abscess 10
Empyema 120k
 (duration) yrs. mos. 30 ds.
 CONTRIBUTORY (SECONDARY) Lobar pneumonia
Empyema (duration) yrs. mos. 30 ds.
 18. WHERE WAS DISEASE CONTRACTED 10/10
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 20 19 29
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Subacute & chronic
 (Signed) Earl H. Mosper M. D.
8/22 19 29 (Address) 231 W. 13th 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 St. Moriah DATE OF BURIAL 8/23 19 29
 20. UNDERTAKER Greenian Mortuary ADDRESS 104 W. 42nd St.

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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W. J. H. H. H. H.

231 W. 10th St. S. D. S. D.

1130 P. M.