

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. 2641 Forest (Fellows Convalescent Home))

File No. 30828
Registered No. 30828 Ward

2. FULL NAME Alice Lobach

(a) Residence. No. 721 W 44th 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20th, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 5 21

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) Easton, Ohio

PARENTS
10. NAME OF FATHER Peter Slater
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER xxxx Fry, Miss
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

14. INFORMANT Edward S. Robach
(Address) 721 W 44th

15. FILED 9/12/29 M. M. Crowe REGISTRAR
cast.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 11 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1 1929 to Sept 11 1929 that I last saw her alive on Sept 10 1929, and that death occurred, on the date stated above, at 5:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute endocarditis
131
191A (duration) 3 yrs. 6 mos. 0 da.
CONTRIBUTORY Septicemia = Chemia
(SECONDARY) (duration) 2 yrs. 0 mos. 0 da.

18. WHERE WAS DISEASE CONTRACTED at her home
19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) W. H. Jones M. D.
9/12, 1929 (Address) 7150 Argyle Blvd

*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 not known DATE OF BURIAL 9-13 29

20. UNDERTAKER M. W. Lindsey ADDRESS Box 1000 Kansas City, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION as very important.

2350

