

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

Do not use this space.

37250

**1. PLACE OF DEATH**

County Jackson  
Township Waller  
City Kansas City (No. St. Joseph)

Registration District No. 399  
Primary Registration District No. 1007  
Ward

File No. 5720  
Registered No. 13-4  
St. 13 (Ward)

**2. FULL NAME**

(a) Residence. No. 1005 Broadway St. 1st Ward.

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 21 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 9 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) Wallerway  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New York City  
(STATE OR COUNTRY) New York

10. NAME OF FATHER R. Feist

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Dont Kubo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

14. INFORMANT Raymond Feist  
(Address) 2718 Kenwood

15. FILED 11/18 29 m m. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 17 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1929, to Nov. 17, 1929 that I last saw him alive on Nov. 17, 1929, and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic myocarditis

CONTRIBUTORY (SECONDARY) enlarged prostate (duration) don't know yrs. mos. ds.  
don't know (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?  
IF NOT A PLACE OF DEATH no  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
(Signed) G. M. Frankenburg M. D.  
Nov 18, 1929 (Address) 824 Rialto 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 Crematorium Elmwood DATE OF BURIAL Nov. 19 1929

20. UNDERTAKER Julian K Davidson ADDRESS 300 Troop

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.

WHILE FILLING OUT THIS IS A PERMANENT RECORD

