

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

Do not use this space.

4877

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City (No. Kansas City General Hosp.)

Registration District No. 399

Primary Registration District No. 10

File No. 526
Registered No. 37 St. 3rd Ward

2. FULL NAME

Mahb Adam
(a) Residence. No. Coates House 1st Ward.

(Usual place of abode) 1001 - 15 - Broadway (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 40 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 9 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
70 4 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel
(c) Name of employer Coates House

9. BIRTHPLACE (CITY OR TOWN) St Leon Indiana
(STATE OR COUNTRY)

10. NAME OF FATHER Robert Mahr

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

12. MAIDEN NAME OF MOTHER Anna M Huffmann

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

14. INFORMANT Recard Gled
(Address) Kansas City Genl Hosp.

15. FILED 74 1936 M. M. Corbett REGISTRAR
Ans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-31, 1930, to 2-1, 1930 that I last saw him alive on 2-1, 1930, and that death occurred, on the date stated above, at 9:25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
8 1/2 hr
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 74001
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. E. Willemsen M. D.

2-2, 19 30 (Address) K. G. Genl Hosp.

*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 Cincinnati Ohio DATE OF BURIAL Feb 4 1930

20. UNDERTAKER H. C. Bergman ADDRESS Kansas City Mo

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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