

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

Do not use this space.

4886

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 3660 Summit)

Registration District No. 399
Primary Registration District No. 1067

File No. _____
Registered No. 535
St. _____ Ward) _____

2. FULL NAME Maud A. Biederman

(a) Residence. No. 4137 State Line St. 7 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 18, 1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
34 4 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. 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) Mo.

10. NAME OF FATHER Robert Lee

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

12. MAIDEN NAME OF MOTHER Sara Frizell

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

14. INFORMANT Al R. Biederman (Address) 4137 State Line

15. FILED 15 19 30 M.M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 2, 1930 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1929, to Feb. 2, 1930, that I last saw him alive on Feb. 2, 1930, and that death occurred, on the date stated above, at 4:20 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pul. Tuberculosis

23A (duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 31 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Xray & sputum exam
(Signed) Lament & E. Good, M. D.

2/4, 1930 (Address) 713 Medical Arts 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 DATE OF BURIAL Feb. 5 1930

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS Kansas City

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

