

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

Do not use this space.

4949

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Jackson Primary Registration District No. 109 1/2
City Kansas City (No. 3825 E 60th St) St. _____ Ward _____

File No. _____
Registered No. 599
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 3825 E 60th St, 16 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND-OF (OR) WIFE OF <u>Carroll Snyder</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 15, 1873</u>		
7. AGE	YEARS <u>57</u>	MONTHS <u>1</u>
	DAYS <u>2</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (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) Illinois

10. NAME OF FATHER George Reinsoehl

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

12. MAIDEN NAME OF MOTHER Henrietta Dehle

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

14. INFORMANT Carroll Snyder
(Address) 3825 E. 60th St.

15. FILED 2/8 30 M.M. Crowe
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1929, to Feb 7 1930 that I last saw him alive on Nov 7 1929, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Uterus

(duration) 4 1/2 yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) 46 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Emil Sheilmann, M. D.
Feb 8, 1930 (Address) 321 Allman Bldg. Ke.

*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 Casey, Ill. DATE OF BURIAL Feb 10 1930

20. UNDERTAKER W.W. Newcomer Sons ADDRESS K.C. 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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Mr Emil Heilmann

321 Altman Bldg

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before 10 am