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

Do not use this space.

5233.

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 801

City Kansas City (No. St Josephs' Hospital St. Ward)

2. FULL NAME Mrs. Josephine M Lockhart

(a) Residence. No. 4227 Blatimore 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Work 1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	58			

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) Illinois

PARENTS

10. NAME OF FATHER Peter Malo

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

12. MAIDEN NAME OF MOTHER Sapherine Kegle

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

14. INFORMANT Gilbert A Lockhart
(Address) 4227 Baltimore

15. FILED 2/26, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24/30 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Feb 24, 1930, that I last saw her alive on Feb 24, 1930, and that death occurred, on the date stated above, at 1 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of Peritoneum

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Uterus

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [signature], M. D.

2/25, 1930 (Address) [illegible]

*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	DATE OF BURIAL
Calvary Cemetery	2/27/30 19
20. UNDERTAKER	**ADDRESS**
Quirk & Tobin--20 W Linwood	K. C. Mo

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH.

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 891

City K City (No.)..... St. ..... Ward)

2. FULL NAME Mrs. Josephine M. Lockhart

(a) Residence. No..... 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 F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 7/26 19 30 M. M. Crowell Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/24 19 30

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of peritoneum

Cancer of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of uterus

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*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 | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

46

REGISTRARS WILL NOT RECEIVE FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

S-5233