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

Do not use this space.

8680

1. PLACE OF DEATH
County: Jackson
Township: Kay
City: K. C. (No. House of Good Shepherd St. Ward)
Registration District No.: 999
Primary Registration District No.: 30
File No.: 14057
Registered No.: 11057

2. FULL NAME: Mary Irma Kegler
(a) Residence. No. House of Good Shepherd St., 8 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 75 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: wh
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): Unknown

7. AGE: Years: about 63 Months: – Days: — If LESS than 1 day, ...hrs. or ....min.

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): Germany

PARENTS
10. NAME OF FATHER: No Data
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): No Data
12. MAIDEN NAME OF MOTHER: No Data
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): No Data

14. INFORMANT: Sisters of Good Shepherd
(Address): 68th & Troost ave

15. FILED 3/9, 1930 M. M. Crowe
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/8/30 19

17. I HEREBY CERTIFY, That I attended deceased from 1-15-29, 19..., to 3-8, 1930, that I last saw her alive on 3-8, 1930, and that death occurred, on the date stated above, at 5:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
93C
82A (duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (SECONDARY): Chronic Myocarditis
Unknown (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? Physical & clinical signs
(Signed) R. R. Anderson M. D.
3/9, 1930 (Address) 200 Bright Bldg. 3 W. Prospect

*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: Calvary Crem
DATE OF BURIAL: 3/10/30 19

20. UNDERTAKER: W. F. Mayberry
ADDRESS: Kan City Mo

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Be sure 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.