

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

Do not use this space.

8944

1. PLACE OF DEATH
 County Jackson Registration District No. 300
 Township Law Primary Registration District No. 3235 Myrtle
 City Kansas City St. 14
2. FULL NAME Carrie Shaw
 (a) Residence. No. 3235 Myrtle St. 14 Ward. 14
 (Usual place of abode) (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.

File No. _____
 Registered No. 1324
 St. _____ Ward) _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank A. Shaw
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18, 1868
7. AGE YEARS 61 MONTHS 4 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Canada
10. NAME OF FATHER August Reibert
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Bloom
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Frank A. Shaw
 (Address) 3235 Myrtle

15. FILED 3/25 30 M. M. Grove
 REGISTRAR Grove

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 25 1930
 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to March 25, 1930
 that I last saw her alive on 2-25, 1930 and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis
131
93A (duration) 5 yrs. 6 mos. 0 ds.
CONTRIBUTORY (SECONDARY) Chronic myocarditis
 (duration) 7 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED? 129 W
 IF NOT AT PLACE OF DEATH _____
19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
20. WAS THERE AN AUTOPSY? no
21. WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) A. Breuler M. D.
3/25 1930 (Address) 402 North Main St.

*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 Mt Washington **DATE OF BURIAL** 3/27 1930

20. UNDERTAKER St. Newcomer's Sons & Co **ADDRESS** _____

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 UNMINDING INK—THIS IS A PERMANENT RECORD

402 Northman Bldg
Lo. 1300 -
1-3