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

Do not use this space.

9031

File No. 8-53
Registered No. 8-46

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: K.C. (No. 4219, East 45th St, Ward)
Registration District No. 399
Primary Registration District No. 1007

2. FULL NAME Mrs Mary Kohrs
(a) Residence. No. 4219 E. 45th 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 7 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)
F	wh	widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17th 1854

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
75	9	17	

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) Germany
12. MAIDEN NAME OF MOTHER Mary Dann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Geo Kohrs
(Address) 4219 East 45th St

15. FILED 3/31, 1930 M. M. Crowe, Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/29/30 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 16, 1930, to Mar 29, 1930 that I last saw her alive on Mar 28, 1930 and that death occurred, on the date stated above, at 11:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Arteriosclerosis (duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) 5 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? Physical Exam
(Signed) [illegible], M. D.
3/30, 1930 (Address) 1303 Waldheim 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	DATE OF BURIAL
Forest Hill Cem	3/31/30 19
20. UNDERTAKER	**ADDRESS**
H. F. Mayberry Co	City

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

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.

W D Stifer
1303 Waldheim
Vic 9168