

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

Do not use this space.

12600

1. PLACE OF DEATH

County Jackson

Registration District No. 325

File No. 1528

Township Ken

Primary Registration District No. 11

Registered No. 1528

City Kansas City

(No. Kansas City General Hospital)

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2514 Indiana St., 11 Ward.

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-17-1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 2 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jackson
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Louis H. Donovan

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

12. MAIDEN NAME OF MOTHER Mariah Tubler

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

14. INFORMANT Recess Lark
(Address) Kansas City Genl Hosp.

15. FILED 4/7, 1930 M. H. Lerner REGISTRAR
West

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-6-1930

17. I HEREBY CERTIFY, That I attended deceased from 3-30-, 1930, to 4-6-, 1930.
that I last saw her alive on 4-6-, 1930, and that death occurred, on the date stated above, at 2:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

carcinoma of thyroid
5 35
49 (duration) yrs. mos. ds.
11 4 B

CONTRIBUTORY (SECONDARY) lung abscess
non tuberculous (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) P. E. Williams, M. D.
4-6-1930 (Address) South K. C. Genl Hosp.

*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 Brooding DATE OF BURIAL 4/8 1930

20. UNDERTAKER D. H. Newman's Sons S. C. S. 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.

NOV 1952