

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

Do not use this space.

12742

1. PLACE OF DEATH

County.....Jackson..... Registration District No. 399
Township.....Kaw..... Primary Registration District No. 1007
City.....Kansas City..... (No. 1819 Washington St. Ward)

File No. 1630
Registered No.

2. FULL NAME.....Margaret M. Matteson.....

(a) Residence. No. 1819 Washington St. 2 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>L. G. Matteson</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 11, 1857</u>			
7. AGE	YEARS	MONTHS	DAYS
	<u>72</u>	<u>11</u>	<u>14</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... <u>At Home</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....			

PARENTS	9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>
	10. NAME OF FATHER <u>Wm Lockhart</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>
	12. MAIDEN NAME OF MOTHER <u>not known</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>	

14. INFORMANT (Address) <u>John B. Matteson</u> <u>1819 Washington</u>
15. FILED <u>491630</u> 19 <u>30</u> <u>M. M. Cofore</u> REGISTRAR <u>Assr</u>

MEDICAL CERTIFICATE OF DEATH

4 16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15, 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929 1929 to April 15 1930 that I last saw h.e. alive on April 15 1930 and that death occurred, on the date stated above, at 11:45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis (Uremic Coma)
..... (duration) ? yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Myocarditis; Secondary Anemia; Uremia
..... (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED ?
IF NOT A PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) Harold M. Roberts M. D.
April 16, 1930 (Address) 910 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Elmwood Cem</u>	DATE OF BURIAL <u>4-18 1930</u>
20. UNDERTAKER <u>Stone & McCreary</u>	ADDRESS <u>Millham Place</u>

WRITE PLAINLY, WITH UNFADING 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.

MARGIN RESERVED FOR BINDING

Dr. Harold M. Roberts

910 Argyle Bldg.,

Vi-8666 -

Office hours 2-5