

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

Do not use this space.

19442

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Townships Raw Primary Registration District No. 1002
 City K. C. Mo. (No. 1105 W. 75th Str. Park) St. _____ Ward _____

File No. _____
 Registered No. 2430

2. FULL NAME

Joan Bidstrup
 (a) Residence No. 1105 W. 75th Str. Park 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. moa. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe. 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 Cery N. Bidstrup

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18 - 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 8 22

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) Aikensville Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER no Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

12. MAIDEN NAME OF MOTHER no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

14. INFORMANT W. S. Bechtel
 (Address) 5631 Wayne Ave. KEMo

15. FILED 6/16, 19 30 M. M. Cronin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1930 to June 10th 1930 that I last saw her alive on June 9th, 1930 and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
82A
91 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Arterio Sclerosis (SECONDARY) (duration) out yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

Place of Death
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) R. C. Regan M. D.
110, 19 30 (Address) 75th + Broadway

*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 Mount Moriah DATE OF BURIAL June 11, 1930

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K. C. Mo.

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.

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15 + 13 Broadway JA-0433
503 W. 74 th 0434