

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

Do not use this space.

19495

1. PLACE OF DEATH

County Jackson
Township Kaw
City K.C.Mo (No. 3309 E 73rd)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2100
St. _____ (Ward)

2. FULL NAME

Carrie Wood Lobdell

(a) Residence. No. 3309 E 73rd St. _____ 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. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elmer E Lobdell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 2 16

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) New York

10. NAME OF FATHER D.C. Wood

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

12. MAIDEN NAME OF MOTHER Hannah Tyler

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

14. INFORMANT Mary W. Buckley (Address) Whitt Plains N.Y.

15. FILED 9/15 30 M.M. Croche REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 1930

17. I HEREBY CERTIFY, That I attended deceased from June 8th, 1930, to June 13th, 1930 that I last saw him alive on June 13, 1930 and that death occurred, on the date stated above, at 4 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Hypostatic Pneumonia
Bronchial pneumonia
11 1/2 (duration) yrs. 7 mos. 7 ds.

CONTRIBUTORY (SECONDARY) Bronchial Asthma (duration) 20 yrs. 7 mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED? 1000
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Zouros Peter, M. D.
6/14, 1930 (Address) 508 Chambers 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 Elmwood DATE OF BURIAL June 16 1930

20. UNDERTAKER Rosa Henderson ADDRESS 150 1/2

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.

3309 E 73rd

Lowell

Dr. W. W. Ritzky
No 6010
5-845-Charlotte
508 Chambers Bldg.