

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

Do not use this space.

19608

1. PLACE OF DEATH

County Jackson
Township Kaw
City K. C. Mo.

399
Registration District No. 001
Primary Registration District No. 001

File No. 2503
Registered No. 2503
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 5627 Lydia 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 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Pfeiffer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27 - 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 3 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School teacher
(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) Kan.

10. NAME OF FATHER David Chapman

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

12. MAIDEN NAME OF MOTHER Sarah Towne

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

14.

INFORMANT W. W. Palmer
(Address) 5627 Lydia Ave. K. C. Mo.

15.

FILED 723 30 M. M. Corvay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1930

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930 to June 23, 1930
that I last saw h. alive on June 22, 1930, and that death occurred, on the date stated above, at 6 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

50 Chromema Breast
1110 (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (SECONDARY) Oedema Sinus
(duration) . yrs. 3 mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. J. Forney M. D.

6'23, 1930 (Address) 821 Angelle 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

Elmwood June 25 19 30

20. UNDERTAKER ADDRESS

Mrs. E. L. Forster 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.

Dr. John J. Corsey

821 Argyle Vi-0860

22 W. 54th

Hi-4351

We-9500