

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

Do not use this space.

26692
3296

1. PLACE OF DEATH

County Jackson Registration District No. 390
Township Kaw Primary Registration District No. 1002
City Kansas City (No. Research Hospital)

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

2. FULL NAME Ora B. Hyer

(a) Residence No. 4819 East 15th St. St. 12 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Stanley M. Hyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 7, 1930

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
56 4 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(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) Iowa

10. NAME OF FATHER H. J. Grimm

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

12. MAIDEN NAME OF MOTHER Orpha Andrews

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

14. INFORMANT Stanley M. Hyer
(Address) 4819 E. 15th St.

15. FILED 8/9/30 in m. m. Crews
REGISTRAR esef

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 7 1930

17. HEREBY CERTIFY, That I attended deceased from Aug 3rd 1930 to Aug 7th 1930 that I last saw him alive on Aug 7th 1930 and that death occurred, on the date stated above, at 9:55 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage & shock.
3 1/2 hrs.
1390
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fibroid tumor and cystic tumor
Non malignant (duration) 7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED out door
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF July 7-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Cytopsin
(Signed) W. J. Frick M. D.
89. 1930 (Address) Rialto 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 Cemetery DATE OF BURIAL 8-9-1930

20. UNDERTAKER Stone & McClure ADDRESS 3235 Gillham Place

4-4-3

72
16

110.

100

1-11

100

Prof. P. S. S.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....
 Town..... Primary Registration District No. 1002 Registered No. 3296
 City X. City (No.) St. Ward)

2. FULL NAME

Ors B Hyen
 (a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED SM (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/2/1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 14 X 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 8/9 19 30 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h. alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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) M. D.

, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-2669R