

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 26734
 Township Paris Primary Registration District No. 1002 Registered No. 0138
 City K.C. Mo. (No. 481 Wallace Ave.) St. _____ Ward _____

2. FULL NAME

Susan McMahon
 (a) Residence. No. 481 Wallace St., 10 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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

Female White Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
no record

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-20-1841

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____hra. or _____min.
	<u>88</u>	<u>11</u>	<u>21</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework
 (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) Penn

10. NAME OF FATHER Samuel Sutz

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

12. MAIDEN NAME OF MOTHER no Record

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

14. INFORMANT Susan McMahon
 (Address) 2515 Chelsea Ave

15. FILED 8/11 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11-1930

17. I HEREBY CERTIFY That I attended deceased from Aug 4, 1930, to Aug 11, 1930 that I last saw her alive on Aug 10, 1930 and that death occurred, on the date stated above, at 6:30 Am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal obstruction
1229 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? NO. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) J. M. St. Evans, M. D.
8/11 1930 (Address) 804 Angyle

*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 St. Washington DATE OF BURIAL Aug-13-1930

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

CAUSE OF DEATH in plain

Angyle Vi - 3277
120 So. Van-Bant - Be1610.
3 P.V.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.
 Township..... Primary Registration District No. 1002 Registered No. 3338
 City St. City of (No.) St. Ward

2. FULL NAME.....

(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 (write the word) Wid

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (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 8/11 1930 M. M. Cerow REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Intestinal Obstruction
 (duration)..... yrs. mos. ds.
 CONTRIBUTORY Fecal impaction
 (SECONDARY) Gradual death
 (duration)..... yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
mf (Signed) Fred. H. Evans, M. D.
11/1, 1930 (Address) 404 apple

*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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

15-26-754