

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

Do not use this space.

26919

File No. _____
Registered No. 3532
St. _____ Ward _____

1. PLACE OF DEATH
County Jackson

Township Kaw

City Kansas City

Registration District No. 399

Primary Registration District No. 1002

(No. 4804 Jefferson

2. FULL NAME Donna Jean Seidel

(a) Residence. No. 4804 Jefferson St. 1 Ward.

(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14, 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>1</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child
(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) Mo

PARENTS	10. NAME OF FATHER <u>Newton W. Seidel</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Elgin Max Illinois</u>
	12. MAIDEN NAME OF MOTHER <u>Edythe Clark</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Cleveland Ohio</u>

14. INFORMANT Newton W. Seidel
(Address) 4804 Jefferson

15. FILED 8/26/30 M. M. Crowe
REGISTRAR

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 26, 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 26, 1930 that I last saw h. alive on Aug 26, 1930 and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute bacterial pneumonia
1123
107A
(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (SECONDARY) Acute tubercle
(duration) _____ yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
1130
 NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF X

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Culture
(Signed) L. E. White, M. D.

8/26, 19 30 (Address) 925 W. 12th St.

*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 <u>Elgin, Ill</u>	DATE OF BURIAL <u>8-27-30</u> 19
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20. UNDERTAKER <u>R. V. Lindsey & Sons, Inc</u>	ADDRESS <u>City Mo</u>
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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.

