

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

Do not use this space.

26979

399

1. PLACE OF DEATH

County Jackson
Towship Kear
City Kansas City Mo (No. St Joseph, Hubs)

Registration District No. 1002
Primary Registration District No. 1002

File No. _____
Registered No. 3596
St. _____ Ward)

2. FULL NAME

Mary Martha Kaiser

(a) Residence. No. 4214 Flora ave St. 15 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31 1930

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City Mo
(STATE OR COUNTRY)

10. NAME OF FATHER E. A Kaiser

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

12. MAIDEN NAME OF MOTHER Estes Mary Phome

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

14. INFORMANT E. A Kaiser
(Address) 4214 Flora Ave

15. FILED 9/1 1930 M. M. Kerowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1930 to Aug 31 1930 that I last saw him alive on _____ 19____ and that death occurred, on the date stated above, at 7:57 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocardial infarction
15AD
(duration) yrs. mos. ds. _____
CONTRIBUTORY (SECONDARY) 15AD
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH St Joseph Hospital

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) J. H. White WILLIAMS M. D.
8/31, 1930 (Address) 925 Wiggles

*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 Mary Cemetery DATE OF BURIAL Sept 1 1930

20. UNDERTAKER John H Wagner ADDRESS 1407 Grand

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.

WHITE PLAINLY, WITH UNWADING INK—THIS IS A PERMANENT RECORD

Dr. W. L. L. L.

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