

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

Do not use this space.

30170

**1. PLACE OF DEATH**

County Jackson Registration District No. ....  
Township Kate Primary Registration District No. ....  
City Kansas City No. 2628 Garfield St. .... Ward) ....

File No. ....  
Registered No. 3978  
St. .... Ward) ....

**2. FULL NAME**

(a) Residence No. 2628 Garfield St. 4 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 F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27-1843

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>87</u>	<u>6</u>	<u>3</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work None 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) Europe

PARENTS	10. NAME OF FATHER <u>Wm Lewis</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Europe</u>
	12. MAIDEN NAME OF MOTHER <u>Elizabeth Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Mrs Lydia Hepler (Address) 665 Woodland

15. FILED 9/30 19 30 M. M. Crowe REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 19 30

17. I HEREBY CERTIFY, That I attended deceased from 9-29-30, 1930, to 9-30-30, 1930, that I last saw him alive on 9-29-30, 1930, and that death occurred, on the date stated above, at 12:15 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocarditis, Chronic  
73C  
(duration) ? yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) NO  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTACTED  
IF NOT AT PLACE OF DEATH .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) Jane M. Smith, M. D.

9/30 19 30 (Address) 818 Rialto Bldg. KC Mo  
\*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>Corder, Mo.</u>	DATE OF BURIAL <u>Oct 2</u> 19 <u>30</u>
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20. UNDERTAKER <u>D. H. Newcomerison K. C. Mo.</u>	ADDRESS
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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.

Roller 0364g.  
D. 4111  
11-5.  
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