

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

Do not use this space.

36358

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. Evangelical hospl)

Registration District No. 399
Primary Registration District No. 002

File No. _____
Registered No. 1208
St. _____ Ward _____

2. FULL NAME Clara Bertha Maule

(a) Residence. No. 2615 Armstrong KCK 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. 2 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) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/20/1871

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|-----------|----------|----------|------|--|
| <u>59</u> | <u>5</u> | <u>3</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). own home
(c) Name of employer self

9. BIRTHPLACE (CITY OR TOWN) Appleton
(STATE OR COUNTRY) Wis.

| | |
|----------------|---|
| PARENTS | 10. NAME OF FATHER <u>---Hoffman</u> |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u> |
| | 12. MAIDEN NAME OF MOTHER <u>unknown</u> |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u> |

14. INFORMANT J. B. Maule
(Address) 2237 Quindaro KCK

15. FILED 1/25 30 M. M. Corvair
REGISTRAR Corvair

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/23 19 30

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1930, to Nov 23 1930 that I last saw her alive on Nov 23 1930, and that death occurred, on the date stated above, at 11 20 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
95B
(duration) 2 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH. HOME

D DID AN OPERATION PRECEDE DEATH? NO. DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Albert S. Harris M. D.
1/24 19 30 (Address) 236 Brookwood Way K.C. 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>Mrs. Hooper</u> | DATE OF BURIAL <u>11/25 1930</u> |
| 20. UNDERTAKER <u>Geo. H. Long</u> | ADDRESS <u>KCK</u> |

K. 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.

Hand DV 0085
236 Road 1207

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