

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

Do not use this space.

39604

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City Mo. (No. 949 West 33th St Terr)

Registration District No. 3015
Primary Registration District No. 5

File No. _____
Registered No. 20178
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 949 West 33th Terr St. 5 Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 - 1857

7. AGE YEARS - MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 - 5 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor
(c) Name of employer, ..

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER John Maense
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Borger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Miss Sophia Maense
(Address) 949 West 33th St Terr

15. FILED 12/25/30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1930

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to Dec 24, 1930. that I last saw alive on Dec 23, 1930, and that death occurred, on the date stated above, at 12:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
97
162
(duration) 3 yrs. - mos. - ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Lynne B. Green M. D.
25. 1930 (Address) 407 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill Cemetery DATE OF BURIAL Dec 26 1930

20. UNDERTAKER John W. Wagner Linwood Wyandotte
ADDRESS _____

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

