

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

Do not use this space.

39685

File No. = 5280
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kear Primary Registration District No. _____
City Kansas City (No. 2818, Charlotte) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2818 Charlotte St. 3 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? 30 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 Bessie C. Waldner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 2, 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 ~~48~~ 8 28

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Home Duties
(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) Austria

10. NAME OF FATHER Adolph Waldner

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

12. MAIDEN NAME OF MOTHER Regina Stern

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

14. INFORMANT Mrs Bessie Waldner
(Address) 2818 Charlotte

15. FILED 12-31-30 m m Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29, 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930 to Dec 29, 1930 that I last saw him alive on Dec 27, 1930 and that death occurred, on the date stated above, at 11 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Influenza Bronchitis

11A (duration) yrs. mos. 7 ds.
11B D
11A CONTRIBUTORY (SECONDARY) Pulmonic Embolus 2 hrs. (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? Symptoms

(Signed) N. D. Gerowich M. D.
12/29 . 1930 (Address) 225 W. Maple St. St. Louis

*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 Sheffield Cem DATE OF BURIAL 12-31-1930

20. UNDERTAKER J. P. Lewis ADDRESS City

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 UNWAVERING INK—THIS IS A PERMANENT RECORD

Handwritten notes or scribbles in the upper right corner.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 5268

City Kansas City (No.)

St. Ward)

2. FULL NAME

(a) Residence, No. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

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

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

Apr 2 1883

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

47

8

28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

1/31 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1930

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-39685