

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

Do not use this space.

1236

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Kansas City, Mo (No. 3908 of Washington) St. _____ Ward _____

File No. _____
 Registered No. 67

2. FULL NAME

(a) Residence. No. 3908 Washington St. 7 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) Dec 20-1855
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 75 0 15
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Engelkenden (STATE OR COUNTRY) Prussia
 10. NAME OF FATHER Charles Heyl
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Mary Hummelhoff
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany (STATE OR COUNTRY) _____

14. INFORMANT Kate Heyl (Address) 3908 Washington
 15. FILED Jan 6 1931 M.S.M. Grove REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931
 17. I HEREBY CERTIFY, That I attended deceased from Dec 30 to Jan 5 1931 that I last saw him alive on Jan 5 1931, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
Probably (duration) 2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Uremic Coma (duration) 3 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 Amputous & 2 (Signed) W. H. Wagner M. D. 1931 (Address) 714 Chacabon Bldg
 *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 Forest Hill DATE OF BURIAL Jan 7 1931
 20. UNDERTAKER John W. Wagner ADDRESS 204 West 11th

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

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.

22 1/2
6 1/2 1/2
7 1/2 4 1/2

11 1/2 5