

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

Do not use this space.

25006

1. PLACE OF DEATH

County Jackson
Township New
City Kansas City

Registration District No. 399
Primary Registration District No. 100
(No. 2840 Woodland Avenue St. _____ Ward _____)

File No. _____
Registered No. 284071
St. _____ Ward _____

2. FULL NAME

Nolan - Katherine Feil
(a) Residence. No. 2840 Woodland Ave St. 11 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 Female 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 William R. Nolan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 - 1878

7. AGE YEARS MONTHS Days If LESS than 1 day, _____ hrs. or _____ min.
53 1 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lawrence
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER George Feil

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

12. MAIDEN NAME OF MOTHER Antoinette Kellerman

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

14. INFORMANT Mrs. J. M. Elm
(Address) 2904 Woodland Ave Kansas City, Mo

15. FILED July 10, 1931 M. M. Crowl
REGISTRAR
Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9th 1931

17. I HEREBY CERTIFY, That I attended deceased from July 9th 1931 to July 9th 1931 that I last saw her alive on July 9th 1931, and that death occurred, on the date stated above, at 8:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage -
with left sided paralysis
131
82H (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial Nephritis (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? Clinical symptoms
Ex. nec. Lead M. D.

(Signed) July 10, 1931 (Address) 2544 Olive

*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 Calvary Cemetery DATE OF BURIAL 7-11 1931

20. UNDERTAKER John J. Sheehan ADDRESS Rt. 2, Mo

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.

MARGIN RESERVED FOR BINDING

V.S. NO. 2.

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