

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.

JUN 19 1934

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

Do not use this space.

16899

1. PLACE OF DEATH

County Jackson Registration District No. 323 File No. _____
 Township Red Primary Registration District No. _____ Registered No. 208
 City Kansas City (No. 7436 Penn) St. _____ Ward _____

2. FULL NAME Doris Catherine Kraus

(a) Residence, No. 7436 Penn 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 Female 4. 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 10 1934

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
		<u>1</u>	<u>12</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Fred Kraus

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pilot Grove, Mo.

15. MAIDEN NAME Cecelia Connolly

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Fred Kraus
 (ADDRESS) 7436 Penn

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE 5/23/34 2 P.M.

19. UNDERTAKER Quirk & Tobin Co.
 (ADDRESS) 20 West Linwood

20. FILED May 22, 1934 M. M. Crowe
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 21 1934 1934

22. I HEREBY CERTIFY, That I attended deceased from May 10, 1934, to May 20, 1934.
 I last saw him alive on May 20, 1934. Death is said to have occurred on the date stated above, at 11:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Whooping Cough
Bronchopneumonia
 Date of onset May 10, 1934

Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify Cholera M. D. _____
 (Signed) Chas. S. Peterson
 (Address) 480 Acyfe Bldg

