

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.

16-223 MAY 24 1935

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

Do not use this space.

12889

1. PLACE OF DEATH

County Jackson Registration District No. 1002  
Township How Primary Registration District No. 2005 Independence  
City Kansas City (No. 2005 Independence)

File No. \_\_\_\_\_  
Registered No. 1501  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Cynthia Fouser  
(a) Residence, No. 2015 Ind. Ave. 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 <u>Fe</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>widow</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>unknown</u>		
7. AGE YEARS <u>61</u>	MONTHS	DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/12/35 1935  
22. I HEREBY CERTIFY, That I attended deceased from mch 12, 1935, to ma 13, 1936  
I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 6:30 p.m.  
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia Date of onset \_\_\_\_\_

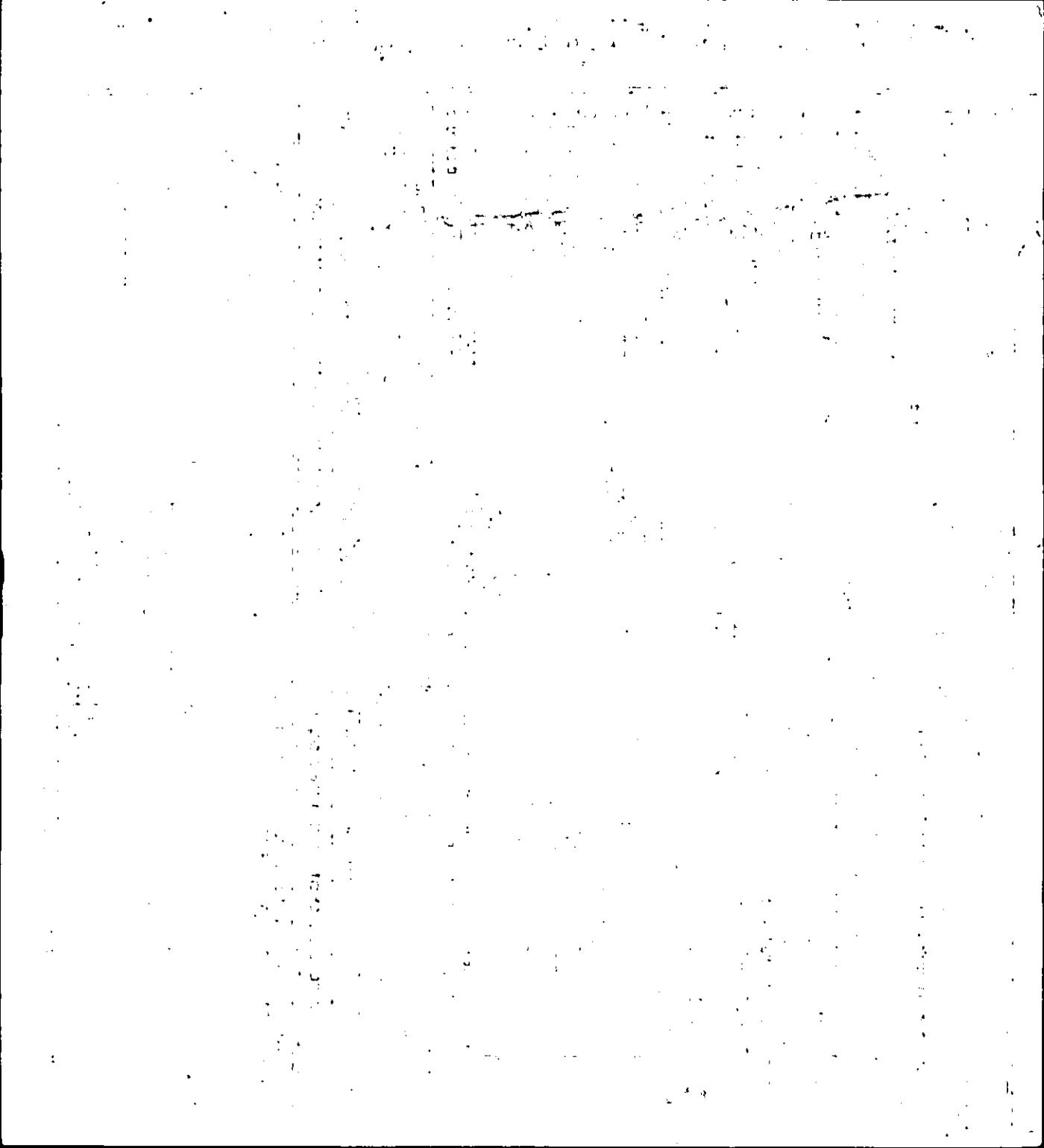
194B

Other contributory causes of importance: \_\_\_\_\_  
Fractured Pelvis about 7 1/2 months ago  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no 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? X  
If so, specify \_\_\_\_\_  
(Signed) D. J. Graham M.D.  
(Address) 811 Chamber Bldg

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown Kentucky</u>
	13. NAME <u>John Boston</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	15. MAIDEN NAME <u>unknown</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
17. INFORMANT <u>Mrs. Myrtle Blausen</u> (ADDRESS) <u>2015 Ind. Ave</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Jefferson City</u> DATE <u>4/15/35</u>	
19. UNDERTAKER (ADDRESS) <u>O. V. MAST FUNERAL HOME, Inc.</u> <u>3146 Main St</u>	
20. FILED <u>4-14</u> 19 <u>35</u> <u>M. M. Crowe, asst Registrar.</u>	



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

Do not use this space.  
ALL INFORMATION OBTAINED  
HEREIN FOR MUST BE WRITTEN  
THIS SUPPLEMENTARY  
File No. \_\_\_\_\_  
Registered No. 15791  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City KANSAS CITY (No. \_\_\_\_\_)

Registration District No. 399  
Primary Registration District No. 1002

**2. FULL NAME**

Cynthia Hauser

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12, 1935

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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 \_\_\_\_\_

The principal cause of death and related causes of importance were as follows:  
1944B  
Other contributory causes of importance:  
Fract. pelvis  
Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 4/14, 1935 M. M. Kerowe Registrar

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? Accid. Date of injury \_\_\_\_\_ 19\_\_\_\_  
Where did injury occur? Don't know (Specify city or town, county, and State)

Specify whether injury occurred in industry, in-home, or in public place. I did not attend to fracture  
Manner of injury you could not get  
Nature of injury that information at your disposal

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Dr. J. J. Johnson M. D.  
(Address) 211 Chamber St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1922  
MAY 6

5-12389

1922  
MAY 6