

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

29370  
4146

**1. PLACE OF DEATH**

County Jackson Registration District No. 000 File No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 City Kansas City (No. 1018) Monroe St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Caroline Matilda Wiechert  
 (a) Residence. No. 1018 Monroe St., \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 1 yrs. 6 mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-1st 1842

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>78</u>	<u>4</u>	<u>17</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housework  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Ohio  
 (STATE OR COUNTRY)

**PARENTS**  
 10. NAME OF FATHER James Jay  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wheeling  
 (STATE OR COUNTRY) W. Va.  
 12. MAIDEN NAME OF MOTHER Mary Law  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wheeling  
 (STATE OR COUNTRY) W. Va.

14. INFORMANT Nannie J. Wiechert  
 (Address) 1014 Monroe

15. FILED 9/20 19 20 M. M. Crane  
 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-18 1920

17. I HEREBY CERTIFY, That I attended deceased from 6-3-20 to 9-18- 1920, and that I last saw her alive on 9-18- 1920, and that death occurred, on the date stated above, at 1140 \_\_\_\_\_ St.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Apoplexy  
 (duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Senility, general debility  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
M. F. E. Hiss M. D.  
 (Address) 708 Garland Ave.  
9/20, 1920

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Savannah Mo. DATE OF BURIAL Sept 21 1920

20. UNDERTAKER Mrs C. L. Horvath ADDRESS W. C. 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.

