

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

Do not use this space.

30321

1. PLACE OF DEATH

County... Jackson
 Township... Kaw
 City... Kansas City

Registration District No. 399
 Primary Registration District No. 1002
 (No. Research Hospital)

File No. 5027
 Registered No. 5027
 St. _____ Ward _____

2. FULL NAME

Mrs. Rosalie Merl

(a) Residence. No. South Park Kansas 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Frank Merl

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10, 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 29

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) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Frank Conrick

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

12. MAIDEN NAME OF MOTHER Susanna Carmann

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

14. INFORMANT Frank Merl (Address) South Park Kansas

15. FILED 10/10 1927 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 9 19 27

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21st 1927, to Oct 9 1927, that I last saw h. W alive on Oct 9 1927, and that death occurred, on the date stated above, at 11:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain tumor, Glioma
53C
E 7 B (duration) yrs. 4 mos. da.
 CONTRIBUTORY (SECONDARY) Cardiac pressure
 (duration) yrs. 3 mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Physical symptoms
 (Signed) B.S. Subbachal M. D.

10/10 19 27 (Address) 1927 Alzyle 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 Shawnee Cemetery DATE OF BURIAL 10/11/27 19

20. UNDERTAKER Quirk & Tobin Co.-20 West Linwood

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.

12608-5

Was this Brain Tu-
mor malignant?

Yes - Glioma
Found by microscopic section

BB

WAIDE

(21)

II. BIRTH

10. NAME

(STATE OR CC

BY

.....

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

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 3827

City Kansas City (No.) St. Ward)

Rosalie Mearl

2. FULL NAME.....

(a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

9. BIRTHPLACE (CITY OR TOWN)

OF COUNTRY

OF FATHER

BIRTHPLACE OF FATHER (CITY OR TOWN)

OF COUNTRY

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

OF COUNTRY

14. INFORMANT

(Address)

15.

FILED 10/10/27 M. M. Crovix REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9 - 19 27

17. I HEREBY CERTIFY, That I attended deceased from
to 19.....
that I last saw h..... alive on....., 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain tumor, Glioma
Glio-sarcoma

CONTRIBUTORY (SECONDARY) Cerebral pressure
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) E. J. Ostry M. D.
, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGIS. FRS SPAL. OT RECEIVE A FEE FOR CERTIFICATES UNTIL THE

K. B.—F. GAUSE

SUPPLEMENTARY

S-30321