

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

Do not use this space.

20697

1. PLACE OF DEATH

County Jackson County Registration District No.
 Township Kaw Primary Registration District No.
 City Kansas City Mo. (No. St Anthony Rome)

File No.
 Registered No. 1-2575
 St. Ward

2. FULL NAME

Mary Lou Shohoney
 (a) Residence. No. 2000 College St. 3 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 3 mos. 29 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
none

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-26-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>3</u>	<u>20</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Larry Shohoney

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

12. MAIDEN NAME OF MOTHER Faltbammer

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

14. INFORMANT Sister Mary Joseph
 (Address) St. Anthony's N. B.

15. FILED 9/3 58 M. W. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-6-1928

17. I HEREBY CERTIFY, That I attended deceased from 6-1-1928 to 6-6-1928, and that I last saw him alive on 6-5-1928, and that death occurred, on the date stated above, at 12:45 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

108 Lobar pneumonia
 (duration) yrs. mos. 6 da.
 CONTRIBUTORY (SECONDARY) 104A
 (duration) yrs. 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? no

WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) H. L. Dwyer M. D.
67, 1928 (Address) 214 Med. Arts 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 St. Marys Cemetery DATE OF BURIAL June 13 1928

20. UNDERTAKER John W. Wagner ADDRESS 1409 Grand Ave

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

