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

Do not use this space.

36957

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 4606

City Kansas City (No. Kansas City Genl Hosp. St. Ward)

2. FULL NAME Cuner, Inez

(a) Residence. No. 1610 Summit 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 2, 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	59	9	13	

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

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

PARENTS

10. NAME OF FATHER Joseph Fisher

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

12. MAIDEN NAME OF MOTHER Martha Carle

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

14. INFORMANT Record Clerk
(Address) K. C. General Hosp.

15. FILED 11/16, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-15 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-18, 1928, to 11-15, 1928 that I last saw her alive on 11-15, 1928 and that death occurred, on the date stated above, at 4:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Encephalitis Lethargica

17 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (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) P. E. Williams, M. D.
11-15, 1928 (Address) Supt K. C. Genl Hosp.

*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
Memorial Park	12/17 1928

20. UNDERTAKER	ADDRESS
Fulton - Eads	K C Ks

N. B.—Every item of information should be carefully [illegible]. 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....

Township N. City Primary Registration District No. 1002 Registered No. 466

City..... (No. ....., ... St. ..... Ward)

2. FULL NAME Crimer, Inez

(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 F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Wid

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

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Uniontown, Pa.

14. INFORMANT .....
(Address)

15. FILED 11-16-1928 M. M. Grove asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-15-1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY (SECONDARY) .....

.....(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) ....., 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

SUPPLEMENTARY

WRITE PLAINLY, WITH STABBING PEN. THIS IS A PERMANENT RECORD

... of information supplied ... should be stated EXACTLY. PHYSICIANS should state ... in plain terms, so ... Exact statement of OCCUPATION is very important.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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