

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

Do not use this space.

1. PLACE OF DEATH

County... Jackson
Township... Raw
City... Kansas City (No. 2807, Mercier)

399

Registration District No. 1002
Primary Registration District No. 1002

40649

File No. 5024
Registered No. _____
St. _____ Ward)

2. FULL NAME Katherine Sprague

(a) Residence. No. 2807 Mercier St. 3 Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Div.

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 9 19 28

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

Sprague

17. HEREBY CERTIFY, That I attended deceased from Oct 29, 1928, to Dec 9, 1928 that I last saw live on Dec 9, 1928, and that death occurred, on the date stated above, at 11.35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis
22A
1236

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13 1898
7. AGE YEARS 29 MONTHS 4 DAYS 26 IF LESS than 1 day, hrs. or mins.

CONTRIBUTORY (SECONDARY) Rectal fistula
(duration) 10 yrs. 10 mos. 10 da.

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

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____ WAS THERE AN AUTOPSY? no

10. NAME OF FATHER Abe Quackenbush

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) D. P. Pfeiffer, M. D. (Address) 2322 Summit

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

12. MAIDEN NAME OF MOTHER Elizabeth Lashbrook

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

*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.

14. INFORMANT Mrs. Elizabeth Quackenbush (Address) 2807 Mercier

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL Dec 11 19 28
20. UNDERTAKER H.W. Gates ADDRESS K.C.K.

15. FILED 12/10/28 M. M. Brown REGISTRAR

Exact statement of OCCUPATION is very important. Pencil plain terms, so that it may be properly transcribed.

20

The first part of the report deals with the general conditions of the country, and the second part with the details of the various districts. The first part is divided into three sections: the first section deals with the general conditions of the country, the second section with the details of the various districts, and the third section with the details of the various districts.

The first section deals with the general conditions of the country, and is divided into three parts: the first part deals with the general conditions of the country, the second part with the details of the various districts, and the third part with the details of the various districts.

The second section deals with the details of the various districts, and is divided into three parts: the first part deals with the details of the various districts, the second part with the details of the various districts, and the third part with the details of the various districts.

The third section deals with the details of the various districts, and is divided into three parts: the first part deals with the details of the various districts, the second part with the details of the various districts, and the third part with the details of the various districts.

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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. 5024
 City K. City (No.) St. Ward)

2. FULL NAME Katherine Sprague

(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 Wid (*write the word*)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13-1899

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
29 4 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

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)

14. INFORMANT

(Address)

15. FILED 12/10/28 M. M. Crowe REGISTRAR

19

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... 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:

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

Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S406 49