

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

Do not use this space.

40680
5055

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Raw Primary Registration District No. 10029 Registered No. _____
 City Kansas City (No. St Joseph's Home for Girls) St. _____ Ward _____

2. FULL NAME

Sister M. Francesca
 (a) Residence. No. St Joseph's Home for Girls Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 5 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 wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 12th 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 9 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Catholic Nun
 (b) General nature of industry, business, or establishment in which employed (or employer). Sisters of St Joseph
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) No Data

PARENTS

10. NAME OF FATHER Wm Schmers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No Data

12. MAIDEN NAME OF MOTHER No Data

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Data

14. INFORMANT

(Address) Sisters of St Joseph
31 st & Jefferson

15. FILED

12/10/1929 M. M. Crowe
 asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1929
 17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Dec 9, 1929
 that I last saw her alive on Dec 7, 1929, and that death occurred, on the date stated above, at 1:2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
131
82
Cerebral Hemorrhage
 Sudden. (duration) yrs. mos. ds.
 CONTRIBUTORY Chronic nephritis
 (SECONDARY) Long Knop (duration) yrs. mos. ds.

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 Laboratory & Clinical
 (Signed) E. E. Eganis M. D.

Dec 9, 1929 (Address) 405 Waldheim 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

DATE OF BURIAL

St Marys Cem 12/12/29

20. UNDERTAKER

ADDRESS

H. F. Mayberry Ks City, Mo.

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.

By *John Coons*
405 Walden
Via 6708

ADDRESS

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OR REMOVAL

DATE OF BURIAL

and (S) Whereof ACCIDENTAL BURIAL or
LIT or in center from UNITED STATES

M. D.

DATE OF

(question) 1st mo yr

(question) 1st mo yr

VS FOLLOWS:

I enclose deceased from
18 and past
18
YEAS) 12

DATE OF DEATH

11 Philip 1st mo yr
cont. like city or town and state)
St Ward)
Registered No
File No