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

Do not use this space.

8926

File No. 1306
Registered No.

1. PLACE OF DEATH
County Jackson — Registration District No. 39
Township Kaw — Primary Registration District No. [illegible]
City Kansas City (No. St. Joseph Hospital St. Ward)

2. FULL NAME Shirlene Sosland
(a) Residence. No. 4957 Virginia St., 15 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	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 3, 1922.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	7	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(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) Missiouri

PARENTS
10. NAME OF FATHER Morris Sosland
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Russia
12. MAIDEN NAME OF MOTHER Etta Remer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New York
(STATE OR COUNTRY) New York

14. INFORMANT Morris Sosland
(Address) 4957 Virginia Ave.

15. FILED 3/24 1930 M. M. Crowe REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22, 1930

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 22, 1930 that I last saw her alive on March 22, 1930, and that death occurred, on the date stated above, at 9:55 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Streptococcic Septicemia
1048
36
4
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Pharangyal Nasal Infection of indeterminable period
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 4957 Virginia
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? General symptoms
(Signed) Geo Ringel, M. D.
March 23 1930 (Address) K C Mo

*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
Mt. Carmel Cemetary.	March 24, 30

20. UNDERTAKER	ADDRESS
J. P. Louis Funeral Director	City.

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.