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

Do not use this space.
16093

File No. D 2001
Registered No.

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City (No. St Anthony Home St., Ward)
Registration District No. 399
Primary Registration District No. 101

2. FULL NAME Mary Elizabeth Rabinette
(a) Residence. No. St. Anthony Home St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
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) 10-18-29
7. AGE: Years | Months: 6 | Days: 17 | If LESS than 1 day, ...hrs. or ...min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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

PARENTS
10. NAME OF FATHER John Rabinette
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ills
12. MAIDEN NAME OF MOTHER Anna Rabinette
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ills

14. INFORMANT Sister Thascia
(Address) St Anthony Baby Home
15. FILED 5/9 1930 M. M. Brown
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1930
17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 5, 1930, that I last saw h. alive on May 5, 1930, and that death occurred, on the date stated above, at 11.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108 (duration) yrs. mos. 4 ds.
CONTRIBUTORY (SECONDARY) None
(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? None
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) A L Dwyer, M.D.
5/6, 1930 (Address) 214 Medical 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: May 8 1930
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.

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