

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

Do not use this space.

OCT 17 1934

1. PLACE OF DEATH

County Jackson
Township Kane
City Kansas City (No. 7406 Chestnut)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 42175
St. _____ Ward)

2. FULL NAME

(a) Residence, No. 7406 Chestnut St. _____ Ward. _____

(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 Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 4, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 7 14

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER FATHER
13. NAME Benj. F. Moyer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

15. MAIDEN NAME Mary E. Keen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT Sydney Dyer (ADDRESS) 7406 Chestnut

18. BURIAL, CREMATION, OR REMOVAL PLACE Long Park DATE Sept 20, 1934

19. UNDERTAKER M. Louis Hudko (ADDRESS) Ill

20. FILED 20 19 34 M. M. Browne Assn Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-18-1934

22. I HEREBY CERTIFY That I attended deceased from Aug 30, 1934, to Sept 18, 1934. I last saw her alive on Sept 18, 1934. Death is said to have occurred on the date stated above, at 9:30 A.M.

The principal cause of death and related causes of importance were as follows:

Aortic insufficiency, present Aug 30
had not examined her before and she had not complained of illness.
Other contributory causes of importance:
pulmonary hemorrhages last 10 days.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? X Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

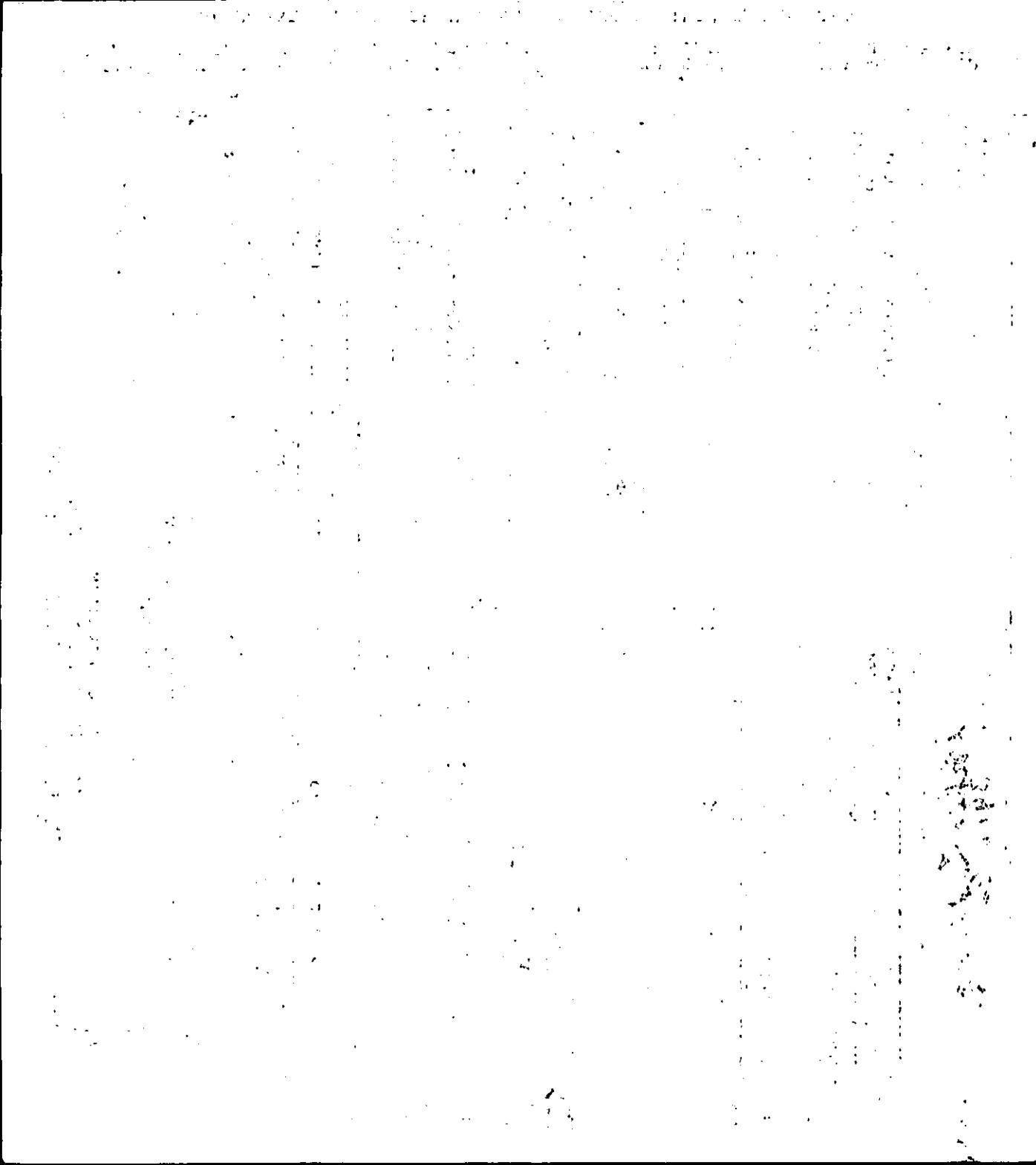
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Richard Adenson M. D.
(Address) 3400 East 31 K.L.ing

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

20322



Kansas City

WASHINGTON

4275

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Effie M Dyer*
Who died at _____ on *Sept 18 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *70* Months *7* Days *14*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: *Pulmonary Hemorrhage from congestion of lungs caused by Agonal valve insufficiency. No tuberculosis in evidence.*

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *Yes*
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician *Arthur L. Hanson - D.O.*
Address of physician *3100 East 21st St*

Signature of Registrar *M. M. Brown* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McLaugh
State Registrar
Special Agent.

Reg. Dist. No. _____
Primary Reg. Dist. No. _____

RECEIVED

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RECEIVED