

JUN 12 1937

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

Do not use this space.

18931

1. PLACE OF DEATH

County Jackson
Township Kay
City Kansas City (No. 2206)

Registration District No. 399
Primary Registration District No. 1002
Oakley

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Martha Lucinda Maxie X. Koons

(a) Residence, No. 2206 Oakley 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 12, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
78 3 24

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) Missouri

FATHER 13. NAME Will Edmisten

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) No record

MOTHER 15. MAIDEN NAME No record

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) No record

17. INFORMANT C. W. Koons
(ADDRESS) 2206 Oakley, Kansas City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Edgewood Cem., DATE May 8-37

19. UNDERTAKER Stine & McClure
(ADDRESS) 3235 Gillham Plaza

20. FILED May 7 37 M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1937

22. I HEREBY CERTIFY That I attended deceased from April 25, 1937 to May 6, 1937
I last saw him alive on May 5, 1937. Death is said to have occurred on the date stated above, at 12:00 Noon PM
The principal cause of death and related causes of importance were as follows:

Terminal Renal Insufficiency Date of onset May 5

Other contributory causes of importance: No
Cancer of Rectum
Fracture Left femur

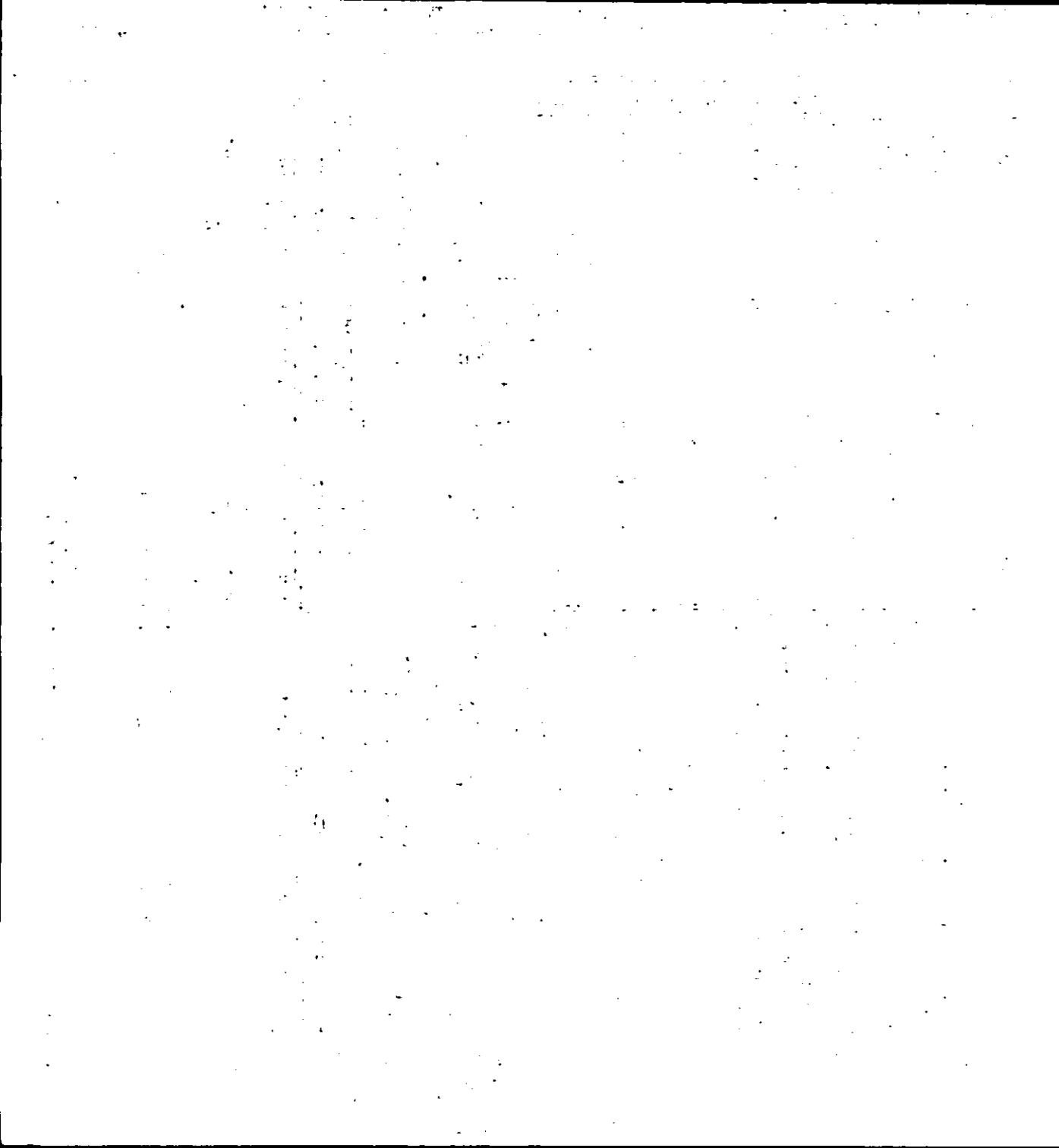
Name of operation None Date of _____
What test confirmed diagnosis? Biopsy Was there an autopsy? Yes

23. 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 _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signature) Wm Sidney Spear, M. D.
(Address) 4301 1/2 E. 11th

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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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. St. Ward)

File No. 2145
Registered No.

2. FULL NAME

(a) Residence, No. 2206 Oakley Ward.
(Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1937

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

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to....., 19.....
I last saw h..... alive on....., 19..... Death is said

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

to have occurred on the date stated above, at.....m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

Terminal Lobar Pneumonia Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

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.....

4/10
Other contributory causes of importance:
Cancer of Rectum
Fracture of Left Femur.
(Pathological)

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

19. UNDERTAKER (ADDRESS)

20. FILED 77 1937 M. M. Brown Registrar.

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury April 1937

Where did injury occur? in home Kansas (Specify city or town, county, and State)

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

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify..... (Signed Wm. L. Spicer M. D.)

(Address) 430 1/2 Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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