Dr. Kuhn

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

Do not use this space.

23832

1. PLACE OF DEATH
County Jackson. Registration District No. 399 File No.
Township Kaw Primary Registration District No. 1002 Registered No. 3188
City Kansas City (No. St Lukes - Hospt St. Ward)

2. FULL NAME Anna Crogan.
(a) Residence. No. St Lukes Hospital Ward. Oneida S. D.
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown
5a. If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF unknown.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown.
7. AGE Years 19 Months — Days — If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) unknown.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER J. J. Drasky.
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown.
14. INFORMANT St Lukes Hospt
(Address) K. C. Mo
15. FILED 8/8-1925 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/6/25 19
17. I HEREBY CERTIFY, That I attended deceased from 7/14/25, 19 to 8/6/25, 19
that I last saw her alive on 8/6/25, 19, and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Uraemia,
121B General Sepsis
152B
36 (duration) yrs. mos. 3 ds.
CONTRIBUTORY (SECONDARY) Appendicitis suppurative
(duration) yrs. mos. 21 ds.
18. Where was disease contracted if not at place of death? Pickwoda.
Did an operation precede death? yes. Date of Jun 25 25
Was there an autopsy? No
What test confirmed diagnosis?
8/6 (Signed) T H McAyllen, M. D.
6, 1925 (Address) 1325 Rialto 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oneida S Dakota DATE OF BURIAL 8-8 1925
20. UNDERTAKER Phil M Ragan ADDRESS 212 Westport

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

1. PLACE OF DEATH
County Jackson Registration District No. 399 File No.
Township Kaw Primary Registration District No. 1002 Registered No. 3138
City Kansas City (No. , St. Ward)

2. FULL NAME Anna Coogan

(a) Residence. No. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Wh	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Daniel Coogan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-1-1906

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	18	9	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Crete Austria

PARENTS
10. NAME OF FATHER J. J. Draxky
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Czechoslovakia
12. MAIDEN NAME OF MOTHER Rosa Kubik
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Lincoln Co Neb

14. INFORMANT J. J. Draxky
(Address) Honeoda S Dak

15. FILED 8 8 1925 M. M. Greene Dep. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 6 1925

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that
death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration)....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....
.....(duration)....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ..... , M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.