

JUN 20 1935

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

Do not use this space.

19333

1. PLACE OF DEATH

County *DeKalb*
Township *Washington*
City (No.) St. Ward

Registration District No. *258*
Primary Registration District No. *0960a*

File No.
Registered No. *5* St. Ward

2. FULL NAME

Jane E Christensen
(a) Residence, No. St. Ward

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 2 1860*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 7 1

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

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) *Clinton Co Mo*

13. NAME *William Hawkins*

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

15. MAIDEN NAME *Susan Webb*

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

17. INFORMANT *Mary Jackson* (ADDRESS) *106 Speer St St Joseph*

18. BURIAL, CREMATION, OR REMOVAL PLACE *M. Lee Cemetery* DATE *June 5 1935*

19. UNDERTAKER *J. J. ...* (ADDRESS) *St. Joseph Mo*

20. FILED *June 5 1935* - *Mrs C A Davis* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-3-1935*

22. I HEREBY CERTIFY, That I attended deceased from *6-3-*, 19*35*, to *---*, 19*---*

I last saw him alive on *6/3*, 19*35*. Death is said

to have occurred on the date stated above, at *8 P* m.

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

Hemiplegia Left
Date of onset
After

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? *clinical* Was there an autopsy? *No*

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? *No*

If so, specify

(Signed) *D L Perkins*, M. D.

(Address) *Charlottesville Mo*

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.

