4092

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

PLACE OF DEATH

County: Saline

Township or Village or City: Nelson

Registration District No. 798 — File No. 4092-a

Primary Registration District No. 4478 — Registered No. 13

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Cora Myrtle Thomas

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	White	married

DATE OF BIRTH: ..... (Month) ..... (Day), 1 (Year)

AGE: 24 yrs. 3 mos. 9 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (City or town, State or foreign country): Saline County

PARENTS
NAME OF FATHER: William Smith
BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri
MAIDEN NAME OF MOTHER: Ritchey (Sarah)
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wesley Thomas

(ADDRESS) Nelson, Mo.

Filed 4/10 1920 Lee S. Shuey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: January (Month) 15th (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6th, 1920, to Jan 15, 1920, that I last saw her alive on Jan 14th, 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

121 B

36

Septicemia

(Duration) — yrs. — mos. 10 ds.

Contributory (SECONDARY) A diseased appendix.

Post Mortem (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Burrett M. D.

Jan 16 1920 (Address) Beack water Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: Nelson Cemetery — DATE OF BURIAL: Jan 16, 1920

UNDERTAKER'S: Nelson + McClelland — ADDRESS: Nelson, 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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ..... St. ..... Ward)

Registration District No. ..... Primary Registration District No. .....

File No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH ..... (Month) ..... (Day), ...

AGE ..... yrs. ..... mos. ..... ds.

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS
- NAME OF FATHER .....
- BIRTHPLACE OF FATHER (City or town, State or foreign country) .....
- MAIDEN NAME OF MOTHER .....
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

I last saw h..... alive on ....., 191.....,

that death occurred, on the date stated above, at ..... m.

CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

ntributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

ed) ..... M. D.

....., 191..... (Address) .....

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TH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR NT RESIDENTS)

ace ..... In the
ath ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.

re was disease contracted
t at place of death? .....

ner or
l residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS

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 import

WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL RECORD