

N. B.—Every item of information should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH **30578**

PLACE OF DEATH
County Andrew
Township Carroll
or
Village Carroll
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 921

File No. _____

Primary Registration District No. 4557

Registered No. _____

FULL NAME Mary a Gladys Ruby

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Female

White

Widowed

DATE OF BIRTH

April 7, 1844
(Month) (Day) (Year)

AGE

78 yrs. 7 mos. 16 ds.

If LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Chesterfield, Mo.

PARENTS

NAME OF FATHER

John F. Roach

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Frankford, Ky.

MAIDEN NAME OF MOTHER

Mary Hall

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Frankford, Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Ruby

(ADDRESS)

Carroll, Mo.

Filed

Dec. 9, 1922

W. F. Ruby

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

November 23, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from October 2, 1922, to November 23, 1922, that I last saw her alive on November 23, 1922, and that death occurred, on the date stated above, at 7 P. M. The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory (SECONDARY)

(Duration) 0 yrs. 1 mos. 22 ds.

(Signed)

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

(Address) Carroll, 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

Carroll, Mo.

DATE OF BURIAL

Nov. 27, 1922

UNDERTAKER

Edgar & Son

ADDRESS

Laddonia, Mo.

PLACE OF DEATH

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

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.

County _____

Township _____ or _____

Village _____ or _____

City _____ (NO. _____) _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

St. _____ Ward _____

(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 (If file the word)
DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____ (Year) _____		
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?		

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)

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

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, 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.

(Signed) _____, 191____ (Address) _____ M. D.

*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 _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____