

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

18063

1. PLACE OF DEATH

County Bates
Township Int. Pleasant
City No. County Infirmary

Registration District No. 50
Primary Registration District No. 5092

File No. 160
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Mrs. Jennie Wallace

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 83

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT Mrs. S. P. Gregg
(Address) Butler Mo.

15. FILED June 11, 1923 J. F. Lockwood
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1923

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to June 4, 1923, that I last saw her alive on June 3, 1923, and that death occurred, on the date stated above, at 1:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis chronic
131

CONTRIBUTORY (SECONDARY)

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) Chas. E. Powers, M. D.
, 19 (Address) Butler Mo.

*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 Oak Hill DATE OF BURIAL June 6 1923
20. UNDERTAKER Culvers ADDRESS Butler 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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) Sl..... Ward.....

2. FULL NAME

(a) Residence, No..... Sl..... 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

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

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

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

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

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

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.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED (duration)..... yrs. mos. ds.
 IF NOT AT PLACE OF DEATH: DATE OF.....

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
 20. UNDERTAKER ADDRESS