LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

30722

ACE OF DEATH

ounty Monroe Registration District No. 579 File No.

ownship Mason Primary Registration District No. 5776 Registered No.

ity (No. St. Ward)

LL NAME Mary Ann Elizabeth Hinley

) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
ale	Colored	married

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
R) WIFE OF

E OF BIRTH (MONTH, DAY AND YEAR) 10/9-23

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

UPATION OF DECEASED
Trade, profession, or
ticular kind of work at Home
General nature of industry,
siness, or establishment in
ich employed (or employer)
Name of employer

THPLACE (CITY OR TOWN)
TATE OR COUNTRY) Monroe Co Mo

NAME OF FATHER Frank Hinley

BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

MAIDEN NAME OF MOTHER Maik Heathman

BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Monroe Co Mo

FORMANT Don Heathman
ddress) Madison Mo

ED. 10/17 19 23 W H Cendrick Registrar
Fred G. Thompson Dept

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/16 1923

17.
I HEREBY CERTIFY, That I attended deceased from ..., 19..., to 10/16, 1923
that I last saw h... alive on 10/16, 1923 and that
death occurred, on the date stated above, at 6 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tetanus Neonatorum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF 0

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? not any

(Signed) C C Smith, M. D
, 19 (Address) Madison, 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 Dunaway Cemetery — DATE OF BURIAL 10/17 1923

20. UNDERTAKER Fred G. Thompson — ADDRESS Madison Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and Sta

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

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 OF
(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)

PARENTS

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)

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

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).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUS (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUIC HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BU

20. UNDERTAKER	ADDRESS