LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

35318

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

1 PLACE OF DEATH

County: Sullivan

Township: Penn
or
Village:
or
City: Green Castle (NO. ..... St.; ..... Ward)

Registration District No. 848 File No. 7

Primary Registration District No. 4514 Registered No. 7

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

2 FULL NAME Julia May Reuse

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 13 (Day) 1888 (Year)

7 AGE: 37 yrs. 4 mos. 27 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Adair Co Mo

PARENTS

10 NAME OF FATHER: N. J. Hammons

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana

12 MAIDEN NAME OF MOTHER: Rebecca Cutberson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ora Hammons
(Address): Green Castle Mo

Filed 12/9/ 1925 Wm Parsons Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 10 (Day) 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ~~Sept~~ 15 1925 to ~~Nov~~ Oct 30 1925 that I last saw her alive on Oct 30 1925 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes 57

59
953 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Heart disease

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

(Signed) W. L. Taylor M. D.

Nov 10 1925 (Address) Green Castle Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Mount Moriah Cem

DATE OF BURIAL: Nov 11 1925

20 UNDERTAKER: G. E. Smiles

ADDRESS: Green Castle Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

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

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

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

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

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

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

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.....n

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....d

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....d

(Signed).....M. D.

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)

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

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

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191
20 UNDERTAKER	**ADDRESS**