LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

APR 24 1926

5346

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

1. PLACE OF DEATH
County Monroe — Registration District No. 579 — File No.
Township Marion — Primary Registration District No. 5776 — Registered No.
~~City Madison~~ (No. ... St. ... Ward)

2. FULL NAME Sophia Berenice Hulen
(a) Residence. No. ... St., ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
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: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Granville Hulen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/30/1884

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
41	3	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Monroe Co. Mo.

PARENTS
10. NAME OF FATHER B. Frank Dry
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Monroe Co. Mo
12. MAIDEN NAME OF MOTHER Mary E. Wright
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Monroe Co. Mo

14. INFORMANT Granville Hulen
(Address) Madison, Mo.

15. FILED 4/10, 1926. W. D. Eubank REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/13 1926

17. I HEREBY CERTIFY, That I attended deceased from 2/9, 1926, to 2/13, 1926 that I last saw her alive on 2/13, 1926, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
132A Nephritis
132B
129B
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Uraemia
(duration) yrs. mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? clin. signs & symp
(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: Dry Cemetery
DATE OF BURIAL: 19

20. UNDERTAKER: Fred A. Thompson
ADDRESS: Madison 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.

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. .....Ward)

2. FULL NAME .....

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

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 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) 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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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) ..... , 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
	19
20. 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 important.