

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

Do not use this space.

7587

1. PLACE OF DEATH

County Clay Registration District No. 198
 Township Eastwood River Primary Registration District No. 3011
 City Ex Spgs (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 38

2. FULL NAME

Mrs. Nellie C. Becket
 (a) Residence No. Chuffman add. St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White Married

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

Robert Becket

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

July 31, 1864

7. AGE

YEARS	MONTHS	DAY	At LESS than 1 day, hrs. or min.
<u>62</u>	<u>7</u>	<u>25</u>	

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) Clay Co

PARENTS

10. NAME OF FATHER

John B. Snyder

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER

Caroline Sparrow

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo. City

14.

INFORMANT Robert Becket
 (Address) Ex Spgs Mo

15.

FILED 3-27-27 yo, Crover REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 27 1927

17. I HEREBY CERTIFY, That I attended deceased from about
Feb. 10, 1927, to Mar. 27, 1927,
 that I last saw her alive on Feb. 27, 1927, and that
 death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

mastoiditis
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Smear
 (Signed) N.A. Grace, M. D.

(Address) 108 Broadway
 *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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Salem Cemetery Mar 28 1927

20. UNDERTAKER

ADDRESS

John C. Prather Ex Spgs

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. DO NOT SIGN THIS CERTIFICATE.

APR 22 1927

