APR 25 1927

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

Do not use this space.

7875

1. PLACE OF DEATH

County: Green — Registration District No. 922 — File No.

Township: Franklin — Primary Registration District No. 5946 — Registered No. 42

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Jennie Albertia Sutherland

(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)
Female	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
		8	29	

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): None
(c) Name of employer: None

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Green Co. Mo.

PARENTS

10. NAME OF FATHER: Tracy H. Sutherland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kansas
12. MAIDEN NAME OF MOTHER: Bula Highfill
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Webster Co. Mo.

14. INFORMANT: Tracy H. Sutherland
(Address): Fair Grove Mo. R. 1.

15. FILED: 3-16-27 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 5 1927

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to March 4, 1927, that I last saw h.er alive on March 4, 1927, and that death occurred, on the date stated above, at March 5 6:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Cold Exposure.
(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. E. Albright, M. D.

March 5, 1927 (Address) Pleasant Hope 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bassett's Cemetery — DATE OF BURIAL: March 6 1927

20. UNDERTAKER: H. G. Grant — ADDRESS: Fair Grove 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHAL NOT ... ERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County: Greene Registration District No.: 322 File No.:

Township: Franklin Primary Registration District No.: 5946 Registered No.: 4

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME Jennie Albertia Sutherland

(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)
F	W	W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 1829

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 8/4, 1927 John Klingner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 1927

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

SUPPLEMENTARY

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