

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

8102

1. PLACE OF DEATH

County Jackson
Township Ray
City St. Louis (No. St. Louis Hospital St. _____ Ward)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 951

2. FULL NAME

(a) Residence. No. 0 Odessa Mo St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town, where death occurred yrs. mos. 1hr How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mr. A. W. Davidson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19 - 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 9 16 =

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) Ballington
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Robt. Flourney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Pralle

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

14. INFORMANT John A. Davidson
(Address) Odessa Mo

15. FILED 3/6 27 M. M. Corone
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

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

17. Deputy Coroner
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:

Fractured
Spinal - R.R. Trauma
from 2:47 AM
11 (duration) yrs. mos. da.

CONTRIBUTORY at Odessa, Mo
(SECONDARY) (duration) yrs. mos. da.

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

Did an operation precede death..... DATE OF.....

Was there an autopsy? Yes

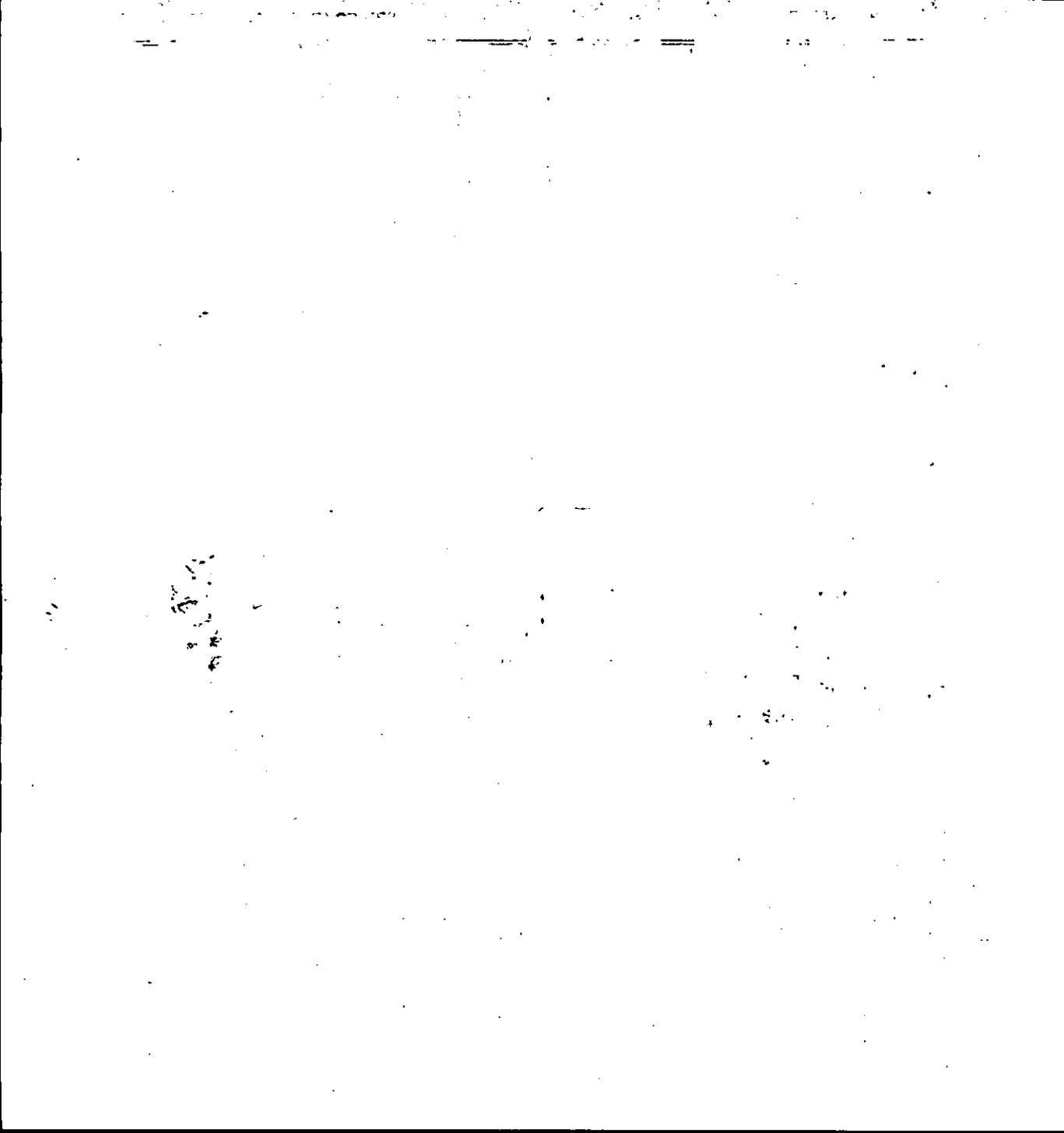
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. A. Nelson, M. D.
3-5, 1927 (Address) Deputy Coroner

*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 Odessa Mo DATE OF BURIAL March 19 27

20. UNDERTAKER Revermi Town ADDRESS City

PARENTS



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jaerson Registration District No. 399 File No. _____
 Township W. City Primary Registration District No. 1082 Registered No. 954
 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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) _____

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 3/6 27 m.m. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 - 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw _____ alive on _____, 19____, and that death occurred, on the date indicated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Fractured skull - R. R. Traumatism - no auto

CONTRIBUTORY (SECONDARY) at Odisa - no

18. WHERE WAS DISEASE CONTRACTED This may have been specific to

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN ACCIDENT? accident WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) Frank Peterson, M. D. _____, 19____ (Address) Springtown

*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

BY LAW ARE COMPLETE AT PREC. ALL NOT R REC

16.15