MAY 26 1927

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

Do not use this space.

11324

1. PLACE OF DEATH
County: DeKalb — Registration District No. 264 — File No.
Township: Grant — Primary Registration District No. 5367 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Stephania M. Titcomb
(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 72 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 25 - 1846

7. AGE: Years 80 — Months 7 — Days 8 — 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): Ia.

PARENTS
10. NAME OF FATHER: Timothy B. Titcomb
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Mary A. Fairar
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Boston (STATE OR COUNTRY): Mass.

14. INFORMANT: O. F. Titcomb
(Address): Maysville, Mo.

15. FILED: Apr 20, 1927 — Mrs. Kessler Green, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927, to April 3, 1927, that I last saw her alive on April 3, 1927, and that death occurred, on the date stated above, at 8 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Angina Pectoris
(duration) ..... yrs. 2 mos. 1 ds.

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

18. WHERE WAS 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? .....
(Signed) L. A. Archer, M.D.
, 19 (Address) Fairport 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: Maysville Cemetery — DATE OF BURIAL: 4/5 1927

20. UNDERTAKER: J. L. Davis — ADDRESS: Maysville, 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.