

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

Do not use this space.

11275A
 13804
 File No. _____
 Registered No. **318** Ward _____

1. PLACE OF DEATH
 County Frank Registration District No. 318
 Township _____ Primary Registration District No. 5440
 City Springfield (No. Monroe Mo.) St. _____ Ward _____

2. FULL NAME Gertrude Dickens
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) Monroe Mo.
 Length of residence in city or town where death occurred yrs. 9 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 W
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 23, 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 26

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

10. NAME OF FATHER Howard Dickens

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

12. MAIDEN NAME OF MOTHER Mary Mallon

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

14. INFORMANT Howard Dickens
 (Address) Monroe Mo.

15. FILED 5/22/27 O. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5, 21, 1927 1927

17. I HEREBY CERTIFY, That I attended deceased from 5:17 1927 to 5:30 1927 that I last saw her alive on 5:30 1927 and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronch. Pneumonia
 (duration) _____ yrs. _____ mos. 7 ds.
 CONTRIBUTORY two Broken ribs (SECONDARY)
 (duration) _____ yrs. _____ mos. 0 ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. H. P. Lewis M. D.
22 1927 (Address) 207 Vermont

*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 Dodson Cemetery DATE OF BURIAL 5/22/27

20. UNDERTAKER W. H. Carue ADDRESS Monroe Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.
 Township Springfield Primary Registration District No. 5440 Registered No. 318
 City (No.) St. Ward)

2. FULL NAME

Meraldine Slickens
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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. 5/22/27 October 1927
 FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1927

I HEREBY CERTIFY That I attended deceased from
 that I last saw him alive on 19....., and that death occurred, on the date stated above.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Proprio pneumonia
Fell out of Bed, at home,
Plus Broken ribs
 (duration) yrs. mos. da. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PREVENT 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 19
 20. UNDERTAKER ADDRESS

SUPPLEMENTARY

RECEIVED BY LAW AS PRESCRIBED BY LAW
 REGISTRATION should be carefully supplied. AGE should be properly classified. Exact terms, so that it may be properly classified. Exact terms, so that it may be properly classified. Exact terms, so that it may be properly classified.
 RECEIVING A FEE FOR CERTIFICATES UNTIL THEY
 CLEARLY, WITH UNFADING INK--THIS IS A
 RECEIVED BY LAW AS PRESCRIBED BY LAW

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