

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

Do not use this space.

17255

**1. PLACE OF DEATH**

County Shelby  
Township Clay  
City Clarence

Registration District No. 827  
Primary Registration District No. 4500

File No. \_\_\_\_\_  
Registered No. 46  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs Angelina Harvey

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (if nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20-1860

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.  
67 | 0 | 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housekeeper  
(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) Missouri

**10. NAME OF FATHER**

Meridith Clark

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Kentucky

**12. MAIDEN NAME OF MOTHER**

Frances Allison

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Virginia

**14.**

INFORMANT Miss Etta Clark  
(Address) Clarence, Mo.

**15.**

FILED May 28 1927 Ray Hamilton  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1927

17. I HEREBY CERTIFY That I attended deceased from Feb 28 1927 to May 28 1927 that I last saw her alive on May 28 1927 and that death occurred, on the date stated above, at 7:10 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Parenchymatous Nephritis  
CONTRIBUTORY Fracture R femur and R humerus

**18. WHERE WAS DISEASE CONTRACTED**

at Clarence mo

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis

(Signed) D. L. Taylor, M. D.

Address Clarence 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**

St Joseph, Mo. May 30 1927

**20. UNDERTAKER**

E. E. Hopper Clarence, Mo.

R. E.—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.

PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County Shelby Registration District No. 827 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4500 Registered No. 16  
 City Clarence (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mrs Angelina Haney  
 (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** D **4. COLOR OR RACE** W. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Wid

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

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

<b>7. AGE</b>	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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**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 528 1927 Ray Hamilton REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) May 28 1927

**17.** I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Chronic parenchymatous nephritis  
fracture R femur & R humerus  
 (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? leg sidewalk  
 (Signed) \_\_\_\_\_ at Clarence Mo. M. D.  
R L Hulan MD  
 \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in death 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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY RECORD

5-17255