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

Do not use this space. 17256

1. PLACE OF DEATH
County: Shelby — Registration District No.: 827 — File No.:
Township: Clay — Primary Registration District No.: 4500 — Registered No.: 14
City: Clarence (No. ..... St. ..... Ward)

2. FULL NAME: Mrs Nellie M. Ragland
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Enoch Ragland
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 26-1871
7. AGE: Years 56 — Months 2 — Days 5 — If LESS than 1 day, ... hrs. or ..... min.
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

PARENTS
10. NAME OF FATHER: John F. Muldrow
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky
12. MAIDEN NAME OF MOTHER: Deborah Thurman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: Mrs Hazel Long
(Address): Clarence, Mo
15. FILED 5/3 1927 Ray Hamilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 1, 1927
17. I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to May 1, 1927, that I last saw her alive on May 1, 1927, and that death occurred, on the date stated above, at 5 a. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
108
115 A Pneumonia Infections
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Peritonsillar abscess
(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) F K Roy, M. D
5/3, 1927 (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: Shelbina — DATE OF BURIAL: May 3 1927
20. UNDERTAKER: E E Hopper — ADDRESS: Clarence 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.

1-27

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS 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

1. PLACE OF DEATH
County: Shelby — Registration District No.: 827 — File No.:
Township: — Primary Registration District No.: 4500 — Registered No.: 14
City: Clarence (No. ..., St. ..., Ward)

2. FULL NAME: Mrs. Nellie M. Rayland

(a) Residence. No. ..., St., ..., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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): W.

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)

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 5/3, 1927 — Ray Hamilton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 1 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:
Infectious Pneumonia
Lobar Pneumonia
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Peritonsillar abscess
Injection
(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) J. K. Ray, M. D
July 6, 1927 (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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

1010

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