JUL 25 1927

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

Do not use this space.

17676

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Caldwell Registration District No. 101

Township: ..... Primary Registration District No. 5749

City: Mirable (No. ..... St. ..... Ward)

2. FULL NAME: Mary C. White

(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: W. H. White

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 23 1861

7. AGE: Years 66 | Months 1 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

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): Hickory
(STATE OR COUNTRY): Penna

PARENTS

10. NAME OF FATHER: James Marison

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

12. MAIDEN NAME OF MOTHER: Elder Lyle

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

14. INFORMANT: Roy White
(Address): Mirable

15. FILED June 6 1927 Inez J. Ballinger, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May June 4 1927

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to June 4, 1927, that I last saw h.. alive on May 4, 1927, and that death occurred, on the date stated above, at 9 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

Hypertension (duration) ..... yrs. ..... mos. 33 ds.

CONTRIBUTORY (SECONDARY): Extensive Varicosed

Angiitis (duration) ..... yrs. 6 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? Clinical Symptoms

(Signed) B. F. Loan, M. D.

, 19 (Address) Polo 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: Mirable

DATE OF BURIAL: June 6 1927

20. UNDERTAKER: Aspaugh & Cowley

ADDRESS: Polo 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.