JUL 27 1927

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

Do not use this space

18127

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Howell

Township: Bry Creek

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

Registration District No.: 387

Primary Registration District No.: 5-5-40

2. FULL NAME Margaret C. Umshler

(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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/27/48

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	7	24	

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) Mo

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

14. INFORMANT Arthur M. Umshler
(Address) Chicago

15. FILED 6-22 1927 D D Cox M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to June 21, 1927, that I last saw h.... alive on June 21, 1927, and that death occurred, on the date stated above, at 8 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Obstructed Ileus
(Impression of Ileus)
50%

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) abdominal & pelvic mass, malignant tumor, undiagnosed

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Mountain View Mo

IF NOT AT PLACE OF DEATH? At her home

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) D D Cox, M. D

6-21, 1927 (Address) Pomona 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 Cheyenne

DATE OF BURIAL 19

20. UNDERTAKER George S. Stapp

ADDRESS West Plains Mo

RECORD every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Howell — Registration District No. 387 — File No. .....
Township Dry Creek — Primary Registration District No. 5540 — Registered No. .....
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Margaret C. Umshler
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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 6/22 1927 D. D. Cox M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 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:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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? .....

Body was shipped to Cheyenne, don't know the date of burial

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL X 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.—F... ...GE should be stated EXACTLY. PHYSICIANS ... ...ssified. Exact statement of OCCUPATION is ... ARE COMPLETE AS PRESC... ...GIST ... RECEIVE A FEE FOR CERTIFICATES U... ...ERMANEN RECORD

S-18127