

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

19037

1. PLACE OF DEATH

County NewtonRegistration District No. 614Township GranbyPrimary Registration District No. 4555City Granby (No.)File No. Registered No. 27St. Ward

2. FULL NAME

(a) Residence No. Jane Hathrine Merplay St. Word

(Visual 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 white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF

(OR) WIFE OF

C.B. Merplay

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

May 18 - 1848

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, hrs.

or min.

7817

8. OCCUPATION OF DECEASED

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

Housework

(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

Lee Swindell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

14.

INFORMANT

(Address)

Bro. Beeler's Granby

15.

FILED

L.N.M. Hureau

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR)

June 25 - 1927

17.

I HEREBY CERTIFY, That I attended deceased from June 25 to June 27, 1927, that I last saw her alive on June 24, 1927, and that death occurred, on the date stated above, at 6:45 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hepatic Abscess as a result of obstruction of biliary duct
127D (duration) yrs. 2 mos. ds.

CONTRIBUTORY

(SECONDARY)

127B (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.M. Longley

M.D.

June 25, 1927 (Address) Granby Mo

*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

PLACE OF BURIAL

20. UNDERTAKER

J. Whitman

ADDRESS

Granby

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.

AGI should be as fully supplied. AGI
so the it may be properly classified
each statement of OCCUPANTS in its entirety

**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 Newton
Township Granby
City Granby

Registration District No. 614
Primary Registration District No. 455-5

File No. _____
Registered No. 25-
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(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) Wid.

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.

FILED _____ 19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

(that I last saw him _____, 19____, and that
death occurred, on the date stated above, at _____, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Abscess as a result
of obstruction of
common duct
of salivary gland
causing inflammation
and abscess

CONTRIBUTORY (SECONDARY)
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRAILED

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. W. Langley, M. D.

Aug 15, 1927 (Address) Granby 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

20. UNDERTAKER

ADDRESS

19

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

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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