

AUG 18 1927

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

20521

1. PLACE OF DEATH

County NorthRegistration District No. 909

File No. _____

Township _____

Primary Registration District No. 4545Registered No. 14

City _____

St. _____ Ward _____

2. FUEL NAME

Mary Thomas

(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 27 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 (OR) WIFE OF

John Thomas

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

1865 - May 30

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

62-10

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)

(STATE OR COUNTRY)

North
Ind

10. NAME OF FATHER

Jerry Fisher

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know
Ind

12. MAIDEN NAME OF MOTHER

Holliday

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know
Ind

14.

INFORMANT
(Address)John O. Thomas
Grant City Mo

15.

FILED

7/10/27John Andrews

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June - 10 1927

17.

I HEREBY CERTIFY, That I attended deceased from 11/4, 1927, to June - 10, 1927.that I last saw him alive on June - 10, 1927, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ulcer of stomachCONTRIBUTOR
(SECONDARY)

(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? noWHAT TEST CONFIRMED DIAGNOSIS? Physician findings(Signed) R. J. Rask, M. D.6/30, 1927 (Address) Grant City 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

Grant City Cemetery6-12-1927

20. UNDERTAKER

ADDRESS

Chas. PrichGrant City 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.

RECORD WITH OAKLEIGH INSTITUTIONS IS A PERMANENT RECORD

