

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

Do not use this space.

21360

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Raw Primary Registration District No. 1062 Registered No. 2115
 City R. C. Mo. (No. 2616-E-9th, St.) St. _____ Ward _____

2. FULL NAME

Mary Victoria Church
 (a) Residence. No. 2616 E-9th St. 9 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 Fe 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 | 6 | 4 | =

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) Middlebury
 (STATE OR COUNTRY) New York

10. NAME OF FATHER Stephen Palmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Canada

12. MAIDEN NAME OF MOTHER Marta Miles

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Virginia

14. INFORMANT Cary E. Crabtree
 (Address) 2616 E-9th St.

15. FILED 7/7 27 AM 1927 REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 4/20/27 to 7/4/27 and that I last saw him alive on July 4, 1927, and that death occurred, on the date stated above, at 7:30 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stroke Hemiparesis
 162 (duration) yrs. mos. ds.
 164 (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? no

WHAT TEST CONFIRMED DIAGNOSIS? R. Palmer
 (Signed) _____, M. D.
 7/6, 1927 (Address) 300 E 17th

*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 Davenport Ia DATE OF BURIAL July 7 1927

20. UNDERTAKER Mrs. C. L. Foster ADDRESS R. C. 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.

