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

Do not use this space.

32891

File No. [redacted]
Registered No. [redacted]

1. PLACE OF DEATH
County: Callaway — Registration District No. 104
Township: [redacted] — Primary Registration District No. 3008
City: Fulton — No. ..... St. ..... Ward)

2. FULL NAME: Grace Mary Mann

(a) Residence. No. Chicago Ill. Mo St., ... Ward. State Hospital No 1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U.S., if of foreign birth? 2 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Widow

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

7. AGE: Years 39 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Telephone Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): DK
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: DK
11. BIRTHPLACE OF FATHER (CITY OR TOWN): DK
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: DK
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): DK
(STATE OR COUNTRY)

14. INFORMANT: Secretary Hospital No 1
(Address): Fulton Mo

15. Filed 11-6-1927, 19..
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 5 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1927, 1925, to Nov 5 —, 1927 that I last saw h. alive on Nov 4 —, 1927 and that death occurred, on the date stated above, at 4 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Asthenia Senile
Chronic Interstitial Nephritis
DS
CAD (duration) 2 or more yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 7 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? DK
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. H. Young, M. D
, 19 (Address) State Hospital No 1

*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: Rolla Mo
DATE OF BURIAL: D.K. 19

20. UNDERTAKER: Herndon Taylor
ADDRESS: Fulton Mo

AUG 23 1945

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 Callaway — Registration District No. 104 — File No. .....

Township ..... — Primary Registration District No. 3008 — Registered No. 225

City Fulton (No. ....., ... St. ..... Ward)

2. FULL NAME Grace Money Maker

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	W

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 Nov 6, 1927 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 5 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? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. ... stated EXACTLY. PHYSICIANS should state ... AGE should be statement of OCCUPATION is very important. ... DEATH in plain terms, so that it may be properly classified. Exact state ...

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

S-32891