

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

Do not use this space.

35340

1. PLACE OF DEATH

County.....
Township.....
City..... (No.) St. Ward.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **10525**

2. FULL NAME

(a) Residence. No. **1438 Madison** St., **26** 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

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

6. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF **Thomas Gartland**

7. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 23 - 1849**

8. AGE YEARS MONTHS DYS IF LESS than 1 day, hrs. or min.
78 | 3 | 1

9. 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.....

10. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Delaware**

11. NAME OF FATHER **William McCullough**

12. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

13. MAIDEN NAME OF MOTHER **Mary Miller**

14. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

15. INFORMANT **Andrew McCullough**
(Address) **1438 Madison**

16. FILED **Nov 25 1927** **Marb Starckoff**
REGISTERED

MEDICAL CERTIFICATE OF DEATH

17. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 24 1927**

I HEREBY CERTIFY, That I attended deceased from **Nov 1**, 1927, to **Nov 23**, 1927, that I last saw her alive on **Nov 22**, 1927, and that death occurred, on the date stated above, at **5:30 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11/24 Acute Bronchitis non Tubercular
(duration) yrs. mos. ds. **28**

CONTRIBUTORY (SECONDARY) **MI**
(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.....
(Signed) **George Mueller**, M. D.

(Address) **125 Madison**

*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 **Cealvary** DATE OF BURIAL **Nov 25 1927**

20. UNDERTAKER **Bensiek-Mehrus** ADDRESS **113876**

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

