

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

Do not use this space.

37923

1. PLACE OF DEATH

County Ripley
Township Thomas
City..... (No.....).....

Registration District No. 701
Primary Registration District No. 0990

File No. 190
Registered No. 31
St. Ward.....

2. FULL NAME Mary Ellen Denton

(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 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas W. Denton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 10, 1854

7. AGE 73 YEARS MONTHS + DAYS + If LESS than 1 day, hrs. or min.

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) dont know
(STATE OR COUNTRY) Franklin Co. Mo

PARENTS

10. NAME OF FATHER Chas. Whittier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) dont know
(STATE OR COUNTRY) dont know

12. MAIDEN NAME OF MOTHER dont know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) dont know
(STATE OR COUNTRY) dont know

14. INFORMANT Mary H. Bancorn
(Address) Naylor, Mo

15. FILED 11/17 1927 RE Whit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 16, 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1927, to Dec 16, 1927 that I last saw him alive on 9.30 1927, and that death occurred, on the date stated above, at 9.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy or cerebral thrombosis
82A
102 (duration) yrs. mos. 1 da.
CONTRIBUTORY High blood pressure
(SECONDARY) (duration) (?) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

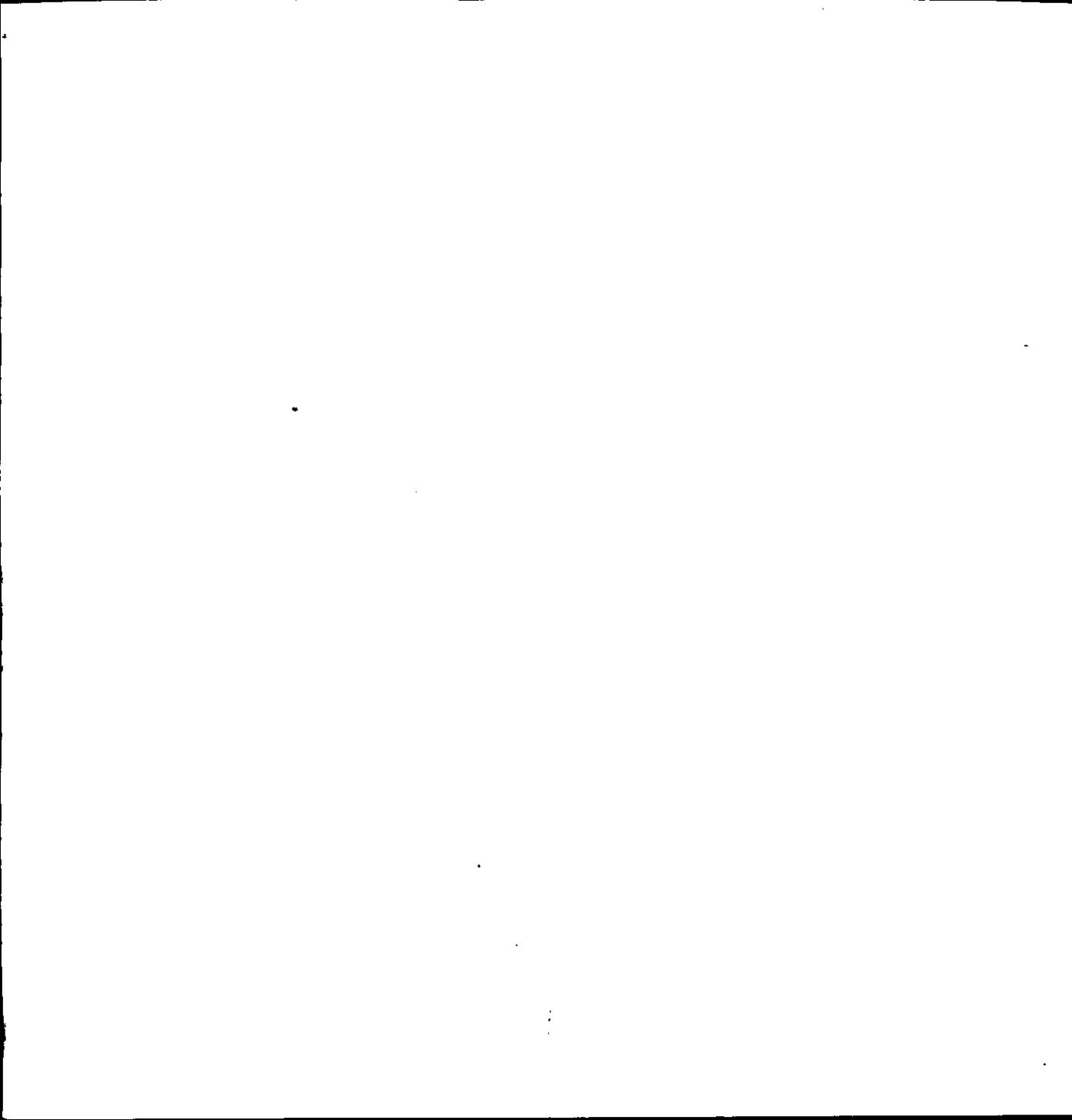
(Signed) RE Whit, M. D.

11/16 1927 (Address) Naylor 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 Naylor Cem DATE OF BURIAL Dec. 18 1927

20. UNDERTAKER Mrs. M. Gish ADDRESS Naylor Mo



**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 Pike
Township Shannon
City..... (No.....)..... St. Ward)

Registration District No. 35-1
Primary Registration District No. 3-990

File No. 190
Registered No. 31

2. FULL NAME

Mary Ellen Denton

(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 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 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.
73 3 1

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 4/25 1924

Heulth
REGISTER

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from 19....., 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:

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... DATE OF.....

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

20. UNDERTAKER ADDRESS

01 .CEIVE A FEE FOR CERTIFICATES U 'IL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-37923