

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

Do not use this space.
1910

1. PLACE OF DEATH

County Montgomery Registration District No. 592 File No. 6
 Township 11 Primary Registration District No. 5790 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mary Bojps

(a) Residence. No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rach Bojps

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31 - 1835

7. AGE YEARS 91 MONTHS 9 DAYS 1 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) Germany

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 C. J. Suckitt (Address) Montgomery City, Mo

15. FILED 3/10, 1928 A. J. Bunker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 7th, 1928

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____. I last saw him _____ alive on _____ 19____ and that death occurred, on the date stated above, at _____ physician _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
I have known her & know the circumstances of her death. Am signing certificate as acting physician by health officer. She died on account of the infirmities of old age.
 18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: _____
4-20 AM 1928, 1-31

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. E. Munday, M. D.
 _____, 19____ (Address) Montgomery City, Mo.

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSE, 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 W. Montgomery City, Mo. ADDRESS _____
W. Montgomery City, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. MAR 20 1928

92-7-2

**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 Montgomery Registration District No. 592 File No. 6
 Township " " Primary Registration District No. 5990 Registered No.
 City..... (No.....) St. Ward.....

2. FULL NAME Mary Baffa

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31-1825

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
X 92 X 7 X 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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 May 10, 1928 D. J. Bentley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... 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.....

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important.
 at it is properly classified. Exact statement of OCCUPATION is very important.
 CAUTION

SUPPLEMENTARY

S-1910