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.

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

Do not use this space.

2878

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 461

City Morris (No. City Hospital St. ..... Ward)

13632

2. FULL NAME Jane McCauley

(a) Residence. No. 1355 Cass St., 11 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 - 1889

7. AGE: Years 8 | Months 4 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Seamstress
(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) Reed Grove

PARENTS
10. NAME OF FATHER Charles McCauley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Jane Martin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Hospital Information
(Address) E Rowan City Hospital

15. FILED JAN 13 1928 Mark Starkoff REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1928 to Jan 12, 1928 that I last saw h. alive on Jan 12, 1928, and that death occurred, on the date stated above, at 10 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
93C Cerebral hemorrhage. Apoplexy
82A Chronic myocarditis
77
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis.
..... (duration) ..... yrs. ..... mos. .....

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Robert H. Simpson, M. D
1/12, 1928 (Address) City Hospital

*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: Calvary Cemetery
DATE OF BURIAL: Jan. 14 1928

20. UNDERTAKER: Sullivan Bros
ADDRESS: 1702 Grand Rd.

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..... Registration District No. 291 File No.....

Township..... Primary Registration District No. 1003 Registered No. 461

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

2. FULL NAME Jane McCauby

(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. [redacted]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
68	4	28	

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 APR -9 1928, 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 19 28

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 [redacted]

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

...ation should be carefully supplied. AGE should be ... state ...n terms, so that it may be properly classified. Exact ...ortant.

REG... NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE ... BY LAW

S- 2878