

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

Do not use this space.

*Reinoff*  
4656  
~~4~~

**1. PLACE OF DEATH**

County *Greene* Registration District No. *321*  
Township *Blair* Tertiary Registration District No. *5444*  
City *Springfield* No. *Galloway Mo.* St. *Mo.* (Ward)

File No. *4656*  
Registered No. ~~4~~

**2. FULL NAME**

*Joyla Letta McKenzie*  
(a) Residence. No. *Galloway Mo.* St. *Mo.* Ward *4*  
(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 *Wh* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 11-1887*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*40 2 1*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *homewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Ash Grove Mo.* (STATE OR COUNTRY)

10. NAME OF FATHER *James Smith*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Bellville Mo.* (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Maude Johnson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Gibson Co. Mo.* (STATE OR COUNTRY)

14. INFORMANT *J. H. McKenzie* (Address) *Galloway Missouri*

15. FILED *2-13-28* *W. L. Turner* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-12-1928*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 7<sup>th</sup>* 1928, to *Feb 12<sup>th</sup>* 1928, that I last saw h. *er* alive on *Feb 12<sup>th</sup>* 1928, and that death occurred, on the date stated above, at *6 P* m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Haemorrhage from Anomalous*  
*1248*  
*1196/1226*  
(duration) yrs. mos. ds. *3*

CONTRIBUTORY (SECONDARY) *Contributory cause*  
*March 20,*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH? *over 1913*

19. DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *over 1925*

20. WAS THERE AN AUTOPSY? *No* *(Talma? Benton?)*

WHAT TEST CONFIRMED DIAGNOSIS? *Small intestine*

*(Signed)* *W. L. Turner*, M. D.  
*2/13-28*, 19 (Address) *Galloway 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 *Ash Grove Mo.* DATE OF BURIAL *2-14-1928*

20. UNDERTAKER *Alma Schreyer* ADDRESS *534 St Louis*

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.

