MAR 19 1928

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

Do not use this space.

1. PLACE OF DEATH

County: Iron — Registration District No. 391 File No. 4759

Township: Arcadia Primary Registration District No. 5546a Registered No. 8

City: (No. St. Ward)

2. FULL NAME: Alma Henrietta Mazer —

(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 (write the word): ✓

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR): ✓

7. AGE: YEARS | MONTHS | DAYS: 10 | 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): Ironton City Mo.

PARENTS

10. NAME OF FATHER: H. S. Mazer.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Madison Co. Mo

12. MAIDEN NAME OF MOTHER: Rosa Miller.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Madison Co. Mo

14. INFORMANT: H. S. Mazer. (Address): Arcadia, Mo

15. FILED: 2/20, 1928 Robert A. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 20 1928

17. I HEREBY CERTIFY, That I attended deceased from ___, 19__, to Feb 20, 1928 that I last saw her alive on Feb. 10, 1928, and that death occurred, on the date stated above, at 4:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: ~~Consul~~ Convulsions — Cause unknown. —

86

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 80

(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) R. W. Gay, M. D

2/20, 1928 (Address) Ironton, 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: Liberty Cemetery

DATE OF BURIAL: Feb. 21 1928

20. UNDERTAKER: H. Mickle

ADDRESS: Ironton, Mo

N. B.—Every item of information should be carefully ... should state CAUSE OF DEATH in plain terms, so that it may be properly class... Exact statement of OCCUPATION is very important

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 Iron — Registration District No. 391 — File No. .....

Township Arcadia — Primary Registration District No. 55 — Registered No. .....

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

2. FULL NAME Alma Henerutta Maze

(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 (*write* the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) X Feb 10-1928 X

7. AGE — YEARS — MONTHS — DAYS: 10 — 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)

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 June 3 1928 Robert A Rasche
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-20 1928

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

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

THIS IS A ... RECORD

... mation shou... fully ... AGE should be stated EXACTLY. PHYSICIANS should state ... in plain terms, so ... be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-4759