

MAR 21 1928

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

Do not use this space.

5914

1. PLACE OF DEATH

County Philps
Township St. James
City St. James (No.)

Registration District No. 678
Primary Registration District No. 4404

File No.
Registered No.
St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5a. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF John H Haley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 - 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 | 2 | 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(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) Camford Co.

10. NAME OF FATHER Joel Buzley

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

12. MAIDEN NAME OF MOTHER Mary Buzley

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

14. INFORMANT John H Haley (Address) St. James Mo.

15. FILED 3/5 28 19 28 Henry H. Matton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 17 19 28

17. I HEREBY CERTIFY, That I attended deceased from July, 1926, to Sept. 17, 1928 that I last saw her alive on 24 January 17, 1928, and that death occurred, on the date stated above, at 4, A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis 9:00
9:30

CONTRIBUTORY (SECONDARY) Mitral Regurgitation
(duration) 4 yrs. 2 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?..... no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) William H Brewer, M. D.
2/18/28, 1928 (Address) St James 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 Masonic Amity DATE OF BURIAL Feb. 18 19 28

20. UNDERTAKER Jonas and Deweych ADDRESS St. James Mo.

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.

should state

and should be stated. AGE should be stated. Exact age

USE OF DR. Every

AGE

AGE

AGE

**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 Phelps Registration District No. 678 File No. _____
 Township _____ Primary Registration District No. 4404 Registered No. _____
 City St James (No. _____) St. _____ Ward _____

2. FULL NAME

Martha Isabelle Haley
 (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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 - 1859

AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 X 2 X 20 X

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 2-18-28 Henry H. Walters REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-17-28 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him 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: _____

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

N. F. CA. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE EXACTLY. PHYSICIANS STATEMENT OF OCCUPATION IS VERY IMPORTANT. THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

