21 1928

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

Do not use this space.

7363

1. PLACE OF DEATH
County: Saline
Registration District No. 796
Township:
Primary Registration District No. 3038
City: marshall (No. ..., St. ..., Ward)
File No.
Registered No. 33

2. FULL NAME: Edith adelia Utz

(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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 27 1883

7. AGE: Years 44 Months 8 Days 22 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: nurse
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Matta Bend
(STATE OR COUNTRY): mo.

PARENTS
10. NAME OF FATHER: Rudolph Levy.
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Arrow Rock mo
12. MAIDEN NAME OF MOTHER: Mary Ann Hayes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Slater mo.

14. INFORMANT: Frank Utz
(Address): marshall mo.

15. FILED 2-28 1928. Mrs. John H. McGuire, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-22 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1927, to Feb 22nd, 1928, that I last saw her alive on Feb 22, 1928, and that death occurred on the date stated above, at 6:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Stomatitis affecting entire Alimentary canal, caused by some irritating drug which I was later informed was Mercury
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 1260B
1058
(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? Physical exam
(Signed) C J Warren 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: Ridge Park Cem
DATE OF BURIAL: Feb. 26 1928

20. UNDERTAKER: Vandiver Sweeney
ADDRESS: marshall mo

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: Saline — Registration District No.: 796 — File No.:

Township: — Primary Registration District No.: 2028 — Registered No.:

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

2. FULL NAME Edith Adelia Utz

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27-1883

7. AGE	YEARS	MONTHS	DAYS	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 4-4, 1928. Mrs. John H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-22 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:

Stomach trouble effecting entire alimentary canal caused by some irritating drug which I was later informed (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Medicine taken with good intention (duration) yrs. mos. ds.

Death due to general debility

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) C. F. Warren, 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

1013

S-7363