

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  
Township Marshall  
City Marshall (No. ....) St. .... Ward)

Registration District No. 996  
Primary Registration District No. 3038

File No. ....  
Registered No. 38  
St. .... Ward)

2. FULL NAME

Edith Adelia Uty

(a) Residence. No. .... St. .... Ward. ....  
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

3A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Uty.

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
44 8 22

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) Matla Bend Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Ridolph Levy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Arrow Rock Mo  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Ann Hays  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) State Mo  
(STATE OR COUNTRY)

14. INFORMANT Frank Uty  
(Address) Marshall Mo.

15. FILED 2-28-28 1928 Mrs. John H. M. Currier  
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, 1928 that I last saw him alive on Feb 22 1928, 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 palmar surface, caused by some irritating drug, which I was later informed was Valium or similar (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 12617  
11513 (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) O J Warren D.O.  
, 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 Vandier Sweeney ADDRESS Marshall Mo

PARENTS

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be clearly documented and supported by appropriate evidence. This includes receipts, invoices, and other relevant documents that can be used to verify the accuracy of the records.

In addition, the document highlights the need for regular audits and reviews. By conducting periodic checks, any discrepancies or errors can be identified and corrected promptly. This helps to ensure the integrity and reliability of the financial information being reported.

Furthermore, the document stresses the importance of transparency and accountability. All parties involved in the process should be kept informed of the progress and any potential issues. This fosters trust and ensures that everyone is working towards the same goals.

Finally, the document concludes by reiterating the significance of these practices in achieving long-term success. By adhering to these principles, organizations can build a strong foundation for their financial operations and ensure that they are always in a position to meet their obligations and maximize their potential.

**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. 296 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3038 Registered No. \_\_\_\_\_  
 City Marshall (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Edith Adelia City

(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) M.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (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) \_\_\_\_\_

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 4-4-28 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 him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

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

*Stomachitis effecting entire alimentary canal caused by some irritating drug. I was later informed that some form of medicine was given CONTRIBUTORY to the result of the final death due to general debility.*

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? 10/13 DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) O. 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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

PARENTS

**SUPPLEMENTARY**

S-7363