

24 1928

PHYSICIANS should state  
cause of death. Exact statement of OCCUPATION is very important.

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

Do not use this space.

8382

## 1. PLACE OF DEATH

County *De Kalb*Registration District No. *260*Township *Colfax*Primary Registration District No. *5362*City *Mary Isabel Bottoff* (No. *1*)

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 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. 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

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

*April 16, 1858*

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, .... hrs.  
or .... min.*69**10**23*

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular kind of work*at home*(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)

*Missouri Indiana*

## 10. NAME OF FATHER

*William T. Conyers*

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Kentucky*

## 12. MAIDEN NAME OF MOTHER

*Josephine Holt*

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Indiana*

## 14.

INFORMANT

(Address)

*J. L. Bottoff*  
*Oaborn Mo.*

## 15.

FILED

*3-12, 1928*  
*Winifred W. Moser*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH (MONTH, DAY AND YEAR)

*March 9 1928*

## 17.

I HEREBY CERTIFY, That I attended deceased from *Mar 3*1928, to *March 9, 1928*(that I last saw her alive on *March 8*, 1928 and thatdeath occurred, on the date stated above, at *11 p.m.*

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

*Endocarditis Chronic**92A**90W*

## CONTRIBUTORY

(SECONDARY)

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *W. S. Hale*, M. D.*3/10, 1928* (Address) *Oaborn 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

## DATE OF BURIAL

*Oaborn Cem (Union Sta)* *Mar 11 1928*

## 20. UNDERTAKER

## ADDRESS

*J. W. Poland* *Cameron*

