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

Do not use this space.

10254

File No. .....
Registered No. .....

1. PLACE OF DEATH
County: Randolph  Registration District No.: 735
Township: .....  Primary Registration District No.: 3034
City: Moberly  (No. 419 So. 4th St. ..... Ward)

2. FULL NAME: Susan E. Creson
(a) Residence. No. 419 So. 4th 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 1st 1858

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 70 | 2 | 29 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(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): Mo

PARENTS
10. NAME OF FATHER: Samuel Robb
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Sarah Tessley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Mo

14. INFORMANT: Mrs. R. Allen
(Address): Moberly Mo

15. FILED 3/31, 1928. Dr. A. S. Fleming
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mch 31st 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to Mar 31, 1928, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pelvic Tumor of unknown Origin
5 yrs. (duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (SECONDARY): .....
(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? Clinical
(Signed) M. R. Nolan, M. D.
3-31, 1928 (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: Moberly Mo
DATE OF BURIAL: 4-3rd 1928

20. UNDERTAKER: Mahan & Andes
ADDRESS: Moberly 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.