

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

Do not use this space.

12119-a

1. PLACE OF DEATH

County Wright
Township Montgomery
City Ne

Registration District No. 911
Primary Registration District No. 6227

File No. 12119-a
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. 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)

married

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

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

2-26-1859

7. AGE

YEARS
69

MONTHS

1

DAYS

5

If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

(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

10. NAME OF FATHER

John Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

14.

INFORMANT (Address)

Jim Blackwell
males mo

15.

FILED

4-20-1928

B.L. Johnston

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

2-31-1928

17.

I HEREBY CERTIFY, That I attended deceased from 2-3-1928 to 3-31-1928 that I last saw her alive on 3-31-1928, and that death occurred, on the date stated above, at 1-36 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

off the apoplexy or cerebral hemorrhage

92 H

50 P

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

mitral regurgitation

(duration) 5 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) B.L. Johnston, M.D.

, 19 (Address) males 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

males Cemetery

4-1-1928

20. UNDERTAKER

ADDRESS

W-L. Botton

not Grove 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.

JUL 10 1928

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