

MAY 29 1928

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

Do not use this space.

12506

1. PLACE OF DEATH

County Callaway
Township Ammanse
City (No. _____) _____

Registration District No. 105-
Primary Registration District No. 5713-

File No. _____
Registered No. 9
St. _____ Ward _____

2. FULL NAME

Mary Mildred M^cDonald
(a) Residence of 2nd main 2nd St. Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 28 mos. _____ da. 25 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) Child

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
1 9 25

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) Callaway Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Charley M^cDonald

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chambers
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Mary R. Moseley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Portland
(STATE OR COUNTRY) Missouri

14. INFORMANT (Address) Peter J. McDonald 7110 J. J. Ave. McDonald

15. FILED 4-22-28 W. H. Williams REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21 1928

17. I HEREBY CERTIFY That I attended deceased from 3-29 1928 to 4-21 1928 that I last saw him alive on 4-21 1928 and that death occurred, on the date stated above, at 9:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro-enteritis +
Broncho-Pneumonia
11912

(duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY Erysipelas
(SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 11912
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) W. O. Bayne M. D.
, 19 (Address) Rt 9 Fulton

*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 2nd main cur DATE OF BURIAL 4-22-28
W. H. Williams

20. UNDERTAKER C. W. Morgan ADDRESS Madison

ONLY, WITH UNFADING INK. PERMANENT RECORD.

N. E. If information should be carefully supplied. AGE written in full. EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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 Callaway
Township Argy House
City (No.) St. Ward

Registration District No. 105-
Primary Registration District No. 5-133-

File No.
Registered No. 9

2. FULL NAME

Mary Mildred McDonald

(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 S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-23-1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 9 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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 22 28 W. Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21-28

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and 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:

CONTRIBUTORY (SECONDARY) (duration) 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), 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

UNDERTAKER

ADDRESS

SUPPLEMENTARY

WRITE PLAINLY WITH UNFADING INK. --THIS IS A PERMANENT RECORD

Every entry should be carefully supplied. AGY should be stated EXACTLY. PHYSIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. No statement of OCCUPATION is very important. REG. --ALSO NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETE AS PRESCRIBED BY LAW

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