

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

Do not use this space.

MAY 29 1928

12557

1. PLACE OF DEATH

County Carroll Registration District No. 135
Township Carrollton Primary Registration District No. 5188
City Carrollton (No. _____) St. _____ Ward _____

File No. _____
Registered No. 48
St. _____ Ward _____

2. FULL NAME

Matilda A Dell

(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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-25-1843

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1	
				day, hrs.	or min.
	<u>84</u>	<u>6</u>	<u>24</u>		

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) Illinois

PARENTS

10. NAME OF FATHER Harvey Milton Jarboe

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Amy Richard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Ohio

14. INFORMANT Fred Dell
(Address) Carrollton Mo

15. FILED 4-19-28 ms E E Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18-28

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1928, to April 18, 1928
that I last saw him alive on April 17, 1928, and that death occurred, on the date stated above, at 6:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (film)
11A Bronchial
107A

CONTRIBUTORY (SECONDARY) 110A
(duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Charles S. Austin M. D.
4/19/28 (Address) Carrollton 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 Trotter Cem DATE OF BURIAL 4-20-28

20. UNDERTAKER Staudley ADDRESS Carrollton

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.

