

1928

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

Do not use this space.

13043

1. PLACE OF DEATH

County Henry Co
 Township Painters
 City _____ (No. _____)

Registration District No. 357
 Primary Registration District No. 547R

File No. _____
 Registered No. 7
 St. _____ Ward _____

2. FULL NAMEMarion Drake

(a) Residence. No. Campy St. _____ Ward _____
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS**MEDICAL CERTIFICATE OF DEATH****3. SEX**Me**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**Sarah Jane Drake**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**June 17-**7. AGE**

YEARS

MONTHS

DAYS

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

71929**8. OCCUPATION OF DECEASED**

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

Farmer

(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)Scotland Co Mo**10. NAME OF FATHER**Henry Drake**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)**Ky**12. MAIDEN NAME OF MOTHER**Sarah Jane Drake**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)**Ky**14. INFORMANT (Address)**Sarah Jane Drake**15. FILED**5/101928J. H. Jones

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)April 16- 1928**17.**

I HEREBY CERTIFY, That I attended deceased from Jan 1- 1926, to April 16- 1928.
 that I last saw him alive on April 15- 1928, and that
 death occurred, on the date stated above, at 9- ca.

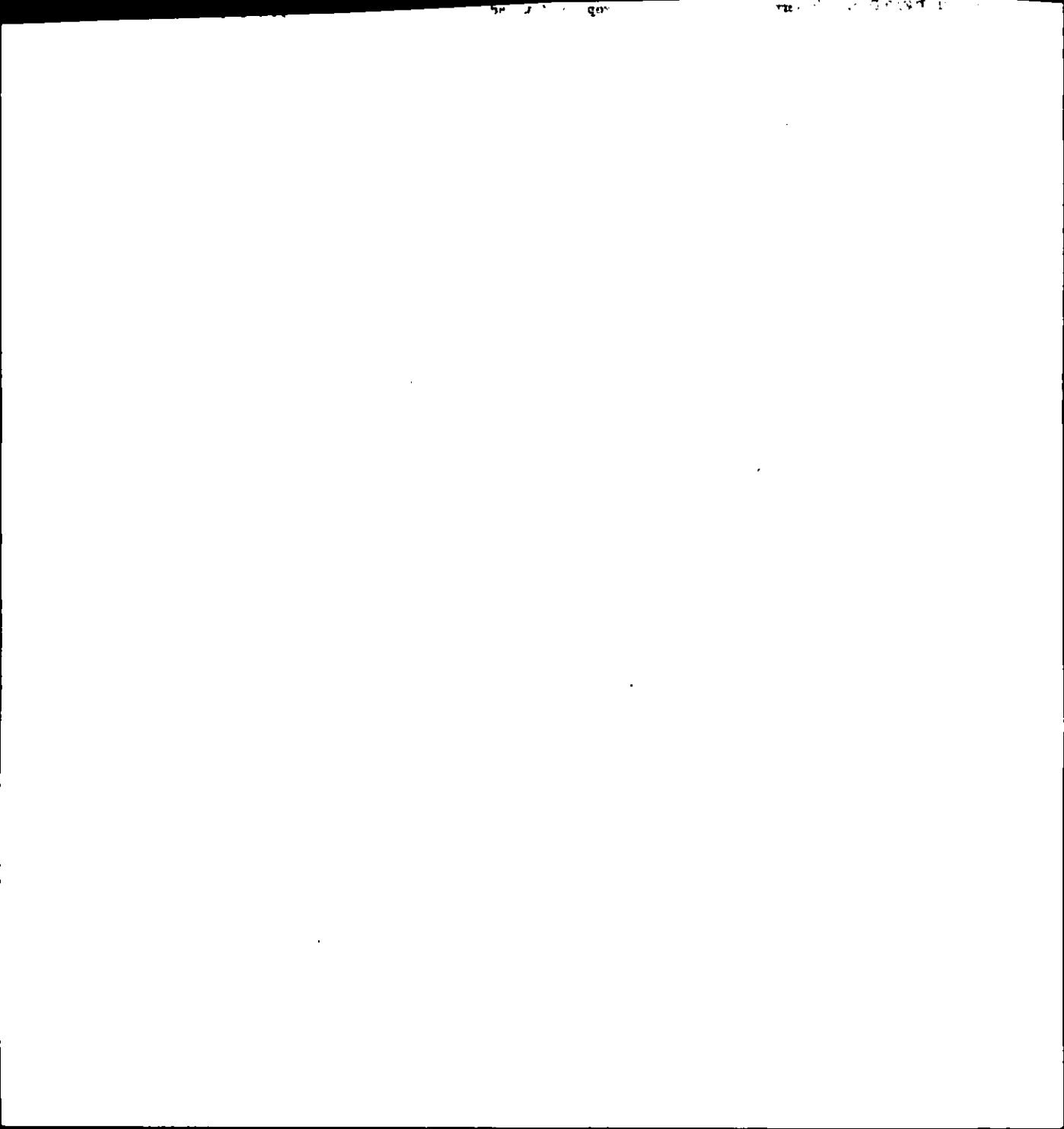
THE CAUSE OF DEATH* WAS AS FOLLOWS:Chronic Dysentery**CONTRIBUTORY (SECONDARY)****18. WHERE WAS DISEASE CONTRACTED**IF NOT AT PLACE OF DEATH, at Home**19. DID AN OPERATION PRECEDE DEATH? DATE OF**WAS THERE AN AUTOPSY? no**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) C. Hayward M. D.
6/10 1928 (Address) Deepwater 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**Brownsville**20. UNDERTAKER****ADDRESS**John HurstDeepwater

CAUSE OF DEATH IN plain terms, so that it may be properly understood.



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 Henry
 Township Hairview
 City (No.)

Registration District No. 35-1
 Primary Registration District No. 5-492

File No.
 Registered No. 7
 St. Ward

2. FULL NAME

Marion Drake

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17 1855

7. AGE YEARS MONTHS DAYS 71 9 29
 If LESS than 1 day, hrs. or min.

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)
 (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 4/16 REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 16 1928

17. I HEREBY CERTIFY, That I attended deceased from , 1928, to , 1928, that I last saw h. after on , 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

 (duration) yrs. mos. ds.
 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 28 (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

20. UNDERTAKER ADDRESS

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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