JUN 1 1928

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

Do not use this space.

File No. 13954

Registered No. 3

1. PLACE OF DEATH

County Linn — Registration District No. 504

Township Grantsville — Primary Registration District No. 5667

City Country (No. ..... St. ..... Ward)

2. FULL NAME Isabelle Jane Hague

(a) Residence. No. Grantsville Twp. St. Country 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: D. C. Hague Deceased Jany 5-1916

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 20th 1852

7. AGE: Years 76 | Months 1 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Homework
(b) General nature of industry, business, or establishment in which employed (or employer): General Housekeeping
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): Near Rockport
(STATE OR COUNTRY): Howard County Mo.

PARENTS

10. NAME OF FATHER: John Pol[illegible] Burroughs
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Boon County Mo
12. MAIDEN NAME OF MOTHER: Mary Jane Ridgway
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Howard County Mo

14. INFORMANT: Nellie E. Maxwell
(Address): R F D Linneus, Mo

15. FILED 4-30, 1928 U C Dryden REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr. 27 1928

17. I HEREBY CERTIFY, That I attended deceased from 14th of April, 1928, to Apr. 27, 1928, that I last saw her alive on Apr. 27th, 1928, and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Paralysis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY): Her age

(duration) ..... yrs. ..... mos. 4 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?

(Signed) J. M. Boyles, M. D

, 19 (Address) Brookfield 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: Bear Branch Cem.
DATE OF BURIAL: Apr 29 1928

20. UNDERTAKER: M. Y. Rusk
ADDRESS: Brookfield

...ery item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... 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: Linn — Registration District No.: 304 — File No.:
Township: Brentwood — Primary Registration District No.: 3667 — Registered No.: 3
City: (No. , St. Ward)

2. FULL NAME: Isabelle Jane Hague

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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*): W

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.

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)

PARENTS
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, 19 — U C Dryden, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 27 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1928, to Apr 27 1928, that I last saw h. alive on Apr 27 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis from
Hemorrhage cerebral
(duration) yrs. mos. 2/3 ds.

CONTRIBUTORY (SECONDARY): age
(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?
(Signed) [illegible], M. D.
, 19 (Address) [illegible]

*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

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

7401

N. B.—Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im[illegible]

RE[illegible] SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETE AS PRESCRIBED BY

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