

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

Do not use this space.

15487 15218

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
1003
Primary Registration District No. 4435A N Market

File No.....
Registered No. 4428
St. Ward)

2. FULL NAME

Jennie Fowler
(a) Residence No. 4435 N Market St.

(Usual place of abode)

Ward.
(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 Col 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) July 13-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 57 9 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Samuel Blend

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

12. MAIDEN NAME OF MOTHER Bel. Hill

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

14. INFORMANT X J.E. Fowler
(Address) 4435 N Market

15. FILED 24 1928 May C. Standon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1928

17. I HEREBY CERTIFY That I attended deceased from 4 21 1928 to 4 22 1928 that I last saw her alive on 4 22 1928, and that death occurred, on the date stated above, at 3 38 PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy of cerebral
hemorrhage
808 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 7401
(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 death

(Signed) H. C. Finley, M. D.
, 19 (Address) 4268 W Finney

*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 Festus Mo. DATE OF BURIAL April 25, 1928

20. UNDERTAKER W.S. Wade. ADDRESS 4202 Finney

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

H. 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.

