

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

Do not use this space.

23072

1. PLACE OF DEATH

County Buchanan Registration District No. 85

Township St. Joseph, Mo. Primary Registration District No. 1001

City St. Joseph, Mo. No. 1006 Dewey Ave. St. _____ Ward)

File No. _____

Registered No. 878

2. FULL NAME

(a) Residence No. 1006 Dewey Ave., St. Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 120 yrs. mos. da. 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 31 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
62 | 5 | 18

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER J. B. French

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

12. MAIDEN NAME OF MOTHER Margaret Hattaway

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Walnut Hedge
(STATE OR COUNTRY) Ind.

14. INFORMANT Mrs. Kearby
(Address) 1006 Dewey Ave

15. FILED 23 1928 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1928

17. I HEREBY CERTIFY That I attended deceased from July 16 1928 to July 19 1928
that I last saw her alive on July 19 1928, and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis.
93A
118C (duration) _____ yrs. mos. 5 da.

CONTRIBUTORY Ac gastritis.
(SECONDARY) (duration) _____ yrs. mos. _____ da.

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) A. W. Kearby, M. D.
(Address) St Joseph 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 Ashland DATE OF BURIAL July 23 1928

20. UNDERTAKER Eleman Funeral Home ADDRESS 1208 Francis

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.

1928

PERMANENT RECORD

CONTINUING INFORMATION IS A

ON DEB

Every Health

... should be carefully supplied. AGE should be taken into account. ... treatment of OCCO ...

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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 Richman Registration District No. 85 File No. _____
 Township St Joe Primary Registration District No. 1001 Registered No. 878
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Minnie Rowbotham
 (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) 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) _____

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 9/18, 1928 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute myocarditis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY acute gastritis
 (SECONDARY) caused by ice cold drinks & food.
 (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) H. D. Keady M. D.
9/18, 1928 (Address) St. Joseph Mo.

*State the DISEASE CAUSING DEATH or its death 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 _____

19

SUPPLEMENTARY

JG 2
 PHYSICIAN
 REGISTRATION NO. _____
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COPIED & PRESCRIBED
 that it may be properly issued.
 REGISTRAR

S-23072