

UG 30 1928

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

Do not use this space.

1. PLACE OF DEATH

County St. LouisRegistration District No. 903Township PlatichallPrimary Registration District No. 4545City Grand City, Mo. (No. _____)File No. 26278Registered No. 15

St. _____

Ward _____

2. FULL NAME

Nancy Jane Gladstone

(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. _____

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)

Married5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(or) WIFE OFAlexander Gladstone

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

Oct 3 1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.6796

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)

Homework

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Washington Co.,

(STATE OR COUNTRY)

Iowa

PARENTS

10. NAME OF FATHER

Samuel Maxwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Houser

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Ohio

14.

INFORMANT

(Address)

Alexander GladstoneGrand City, Mo.

15.

FILED

8/10 28

19

28John Andrews

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

July 9 1928

17.

I HEREBY CERTIFY, That I attended deceased from _____

1927, to _____

1928

that I last saw her alive on _____, 1928, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia and Exhaustion from Paralysis. Was helpless for eleven years.(duration) 11 yrs. _____ mos. _____ da.

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) _____

O. P. N. Mills

M. D.

7/9, 1928

(Address) Grand City, 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

Knox CemeteryJuly 11 1928

20. UNDERTAKER

H. O. MummaRockton

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.

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should be care-
fully supplied. AGE
rms, so that it may be properly classified. E. st.

N. B.—Etc
CAUSE OF

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

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 Worth

Registration District No. 90 3

File No. 13

Township Grant City

Primary Registration District No. 4545

Registered No. 13

City Grant City (No.)

St.

Ward

2. FULL NAME

(a) Residence. No. Nancy Jane Gladstone

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*) M

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 9/10 19 28 John Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 19 28

17.

I HEREBY CERTIFY That I attended deceased from

that I last saw h. alive on , 19 , and that
death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Exhaustion
from paralysis
was
happened
for eleven years
Homeless
Almost equal
Paraplegic, helpless
Back not used
Left Paraplegic helpless

18. WHERE WAS DEATH OCCURRED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) 7500

, M. D.

, 19 (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

19

20. UNDERTAKER

ADDRESS

S-26278