OV 22 1928

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

1. PLACE OF DEATH

County Pemiscot — Registration District No. 65 — File No.

Township Cooter — Primary Registration District No. — Registered No.

City (No. , St. Ward)

2. FULL NAME Susie Catherine Hally

(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: 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: Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12 18 1860

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
63	10	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house wife

(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): none

PARENTS

10. NAME OF FATHER: James Kelum

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): dont Know

12. MAIDEN NAME OF MOTHER: dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): dont Know

14. INFORMANT: Lola McClure
(Address) Cooter Mo

15. FILED 11 10 1924 James A. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 9 1923

17. I HEREBY CERTIFY, That I attended deceased from 9 16 1923, to 10 9 1923, that I last saw her alive on 10 8 1923, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

senile Pelvhely

(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? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) T. A. Cooper, M. D.

, 19 (Address) Cooter 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Union Cemetery Mo

DATE OF BURIAL: 10 10 1923

20. UNDERTAKER: Cooter supply co

ADDRESS: Cooter Mo

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.

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

1. PLACE OF DEATH

County Pemiscot Registration District No. 656 File No.

Township Cooter Primary Registration District No. 58013 Registered No.

City (No. , St.

2. FULL NAME Bernice Erline Rabins

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Infant

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
1921	2	15	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Hiltie Rabins

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

12. MAIDEN NAME OF MOTHER Oma Henley

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

14. INFORMANT Hiltie Rabins
(Address) Cooter Mo

15. FILED 5-27, 1924 James A Jones REGISTRAR

MEDICAL CERTIFICATE OF D

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-26

17. I HEREBY CERTIFY, That I attended
, 19, to
that I last saw h alive on
death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration)

CONTRIBUTORY
(SECONDARY)

(duration)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deat (1) MEANS AND NATURE OF INJURY, and (2) whe HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMO

No 8 Cemetary Mo

20. UNDERTAKER

Cooter supply Co