

3 1928

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

Do not use this space.

39089

1. PLACE OF DEATH

County Saline
Township Slater
City Slater (No. St. Ward)

Registration District No. 799
Primary Registration District No. 4474

File No.
Registered No. 53

2. FULL NAME

Eva Marie Denison

(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 wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/12/19

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
19 3 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 1451
(b) General nature of industry, business, or establishment in which employed (or employer) 1061
(c) Name of employer 170

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo10. NAME OF FATHER J. H. Tompkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill12. MAIDEN NAME OF MOTHER Grace Brewer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14. INFORMANT ms. Grace Tompkins
(Address) Slater Mo

15. FILE NO. 11-23-1928 W. M. Tuttle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1928 to Nov 22, 1928, that I last saw her alive on Nov 22, 1928, and that death occurred, on the date stated above, at 3:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Quercinal Sepsis - Stomach & duodenum & Stomach & duodenum & Stomach & duodenum on 17th day of heavy cold & influenza & Stomach & duodenum
(duration) yrs. mos. ds.

CONTRIBUTORY cold influenza in room
(SECONDARY) no fix
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

8 Did an operation precede death? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. H. Hercules, M. D.
, 19 (Address) Slater 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.

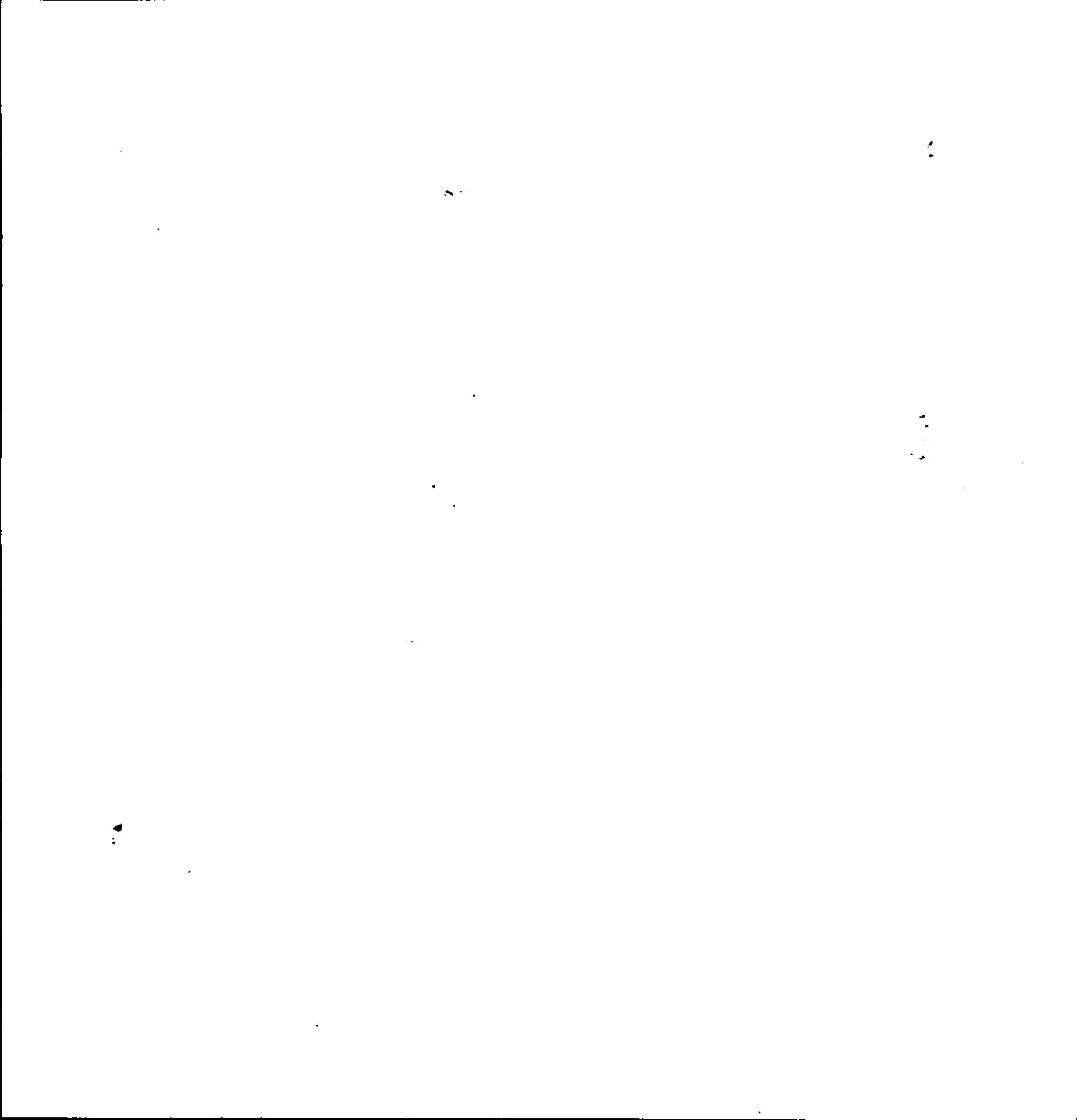
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Slater City Cemetery 11-24 1928

20. UNDERTAKER

ADDRESS

Hill Brothers Slater Mo



**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 Saline Registration District No. 799 File No.
Township Primary Registration District No. 4479 Registered No. 53
City Stater (No.) St. Ward)

2. FULL NAME

Eva Marie Denison

(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 4 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) 8-10-1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 3 12

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 11-23-28 W. M. Tuttle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from to 19..... 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:

CONTRIBUTORY (SECONDARY) (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)....., 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

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

SUPPLEMENTARY

5-39089