

JAN 22 1929

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

Do not use this space.

40078

1. PLACE OF DEATH

County *Platt*
Township *Gladwin*
City

Registration District No. *997*
Primary Registration District No. *6238*

File No. _____
Registered No. *5*
St. _____ Ward _____

2. FULL NAME

Belle G. Terrill

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Terrill*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1849-12-15*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
79 11 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer) *Self*
(c) Name of employer

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

10. NAME OF FATHER *Tracks Parkey*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) *Ky.*

12. MAIDEN NAME OF MOTHER *Margaret Short*

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

14. INFORMANT *Will Pursell*
(Address) *Gladwin Mo*

15. FILED *Jan 10 1929* *F.M. Gladwin*
H.S.P. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 11th 1928*

17. I HEREBY CERTIFY That I attended deceased from *Dec 10th 1928*, to *Dec 11th 1928*, that I last saw her alive on *Dec 10th 1928* and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia, Lobar, Right
108
92B/010
112
Asthma + Lungs Carditis (duration) _____ yrs. _____ mos. *5* da.

CONTRIBUTORY (SECONDARY) _____ (duration) *10* yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Usual Physical*
Dr. C. Pursell M. D.
(Signed) _____
Dec 11, 1928 (Address) *Salem, 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 *Rector Semetary* DATE OF BURIAL *12/13 1928*

20. UNDERTAKER *None* ADDRESS _____

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.

78-11-26

**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 West Registration District No. 997 File No. _____
 Township Gladden Primary Registration District No. 6238 Registered No. 3-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Belle Y. C. Terwill
 (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 F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** W
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1849

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
78 11 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. da.
 (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 Jan 10, 1929 F. M. Jadin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ (that I last saw h. _____ since 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. da.

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

N. B.—E. PHYSICIANS should state state EXACTLY. Exact statement of OCCUPATION is very important. PHYSICIANS should state state EXACTLY. Exact statement of OCCUPATION is very important. **NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW**

SUPPLEMENTARY

S-40078