

JAN 28 1929

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

Do not use this space.

42093

1. PLACE OF DEATH
 County Platte Registration District No. 703
 Township Demersville Primary Registration District No. 5938
 City Flourtown (No. 5982) St. _____ Ward _____

2. FULL NAME Helen M. Breton
 (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 1 yrs. 5 mos. 8 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 Single
 (write the word)

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.
1 5 8

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) Osage Co Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER John L Breton
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Osage Co Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Alma Maryman
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Osage Co Mo
 (STATE OR COUNTRY)

PARENTS

14. INFORMANT Mrs Elva Lyle
 (Address)

15. FILED Jan 18 1929 Dr. Nevins
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to Dec 3, 1928.
 that I last saw her _____ alive on Dec 3, 1928, and that death occurred, on the date stated above, at 2:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Concussion
fall
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY Malnutrition
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

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

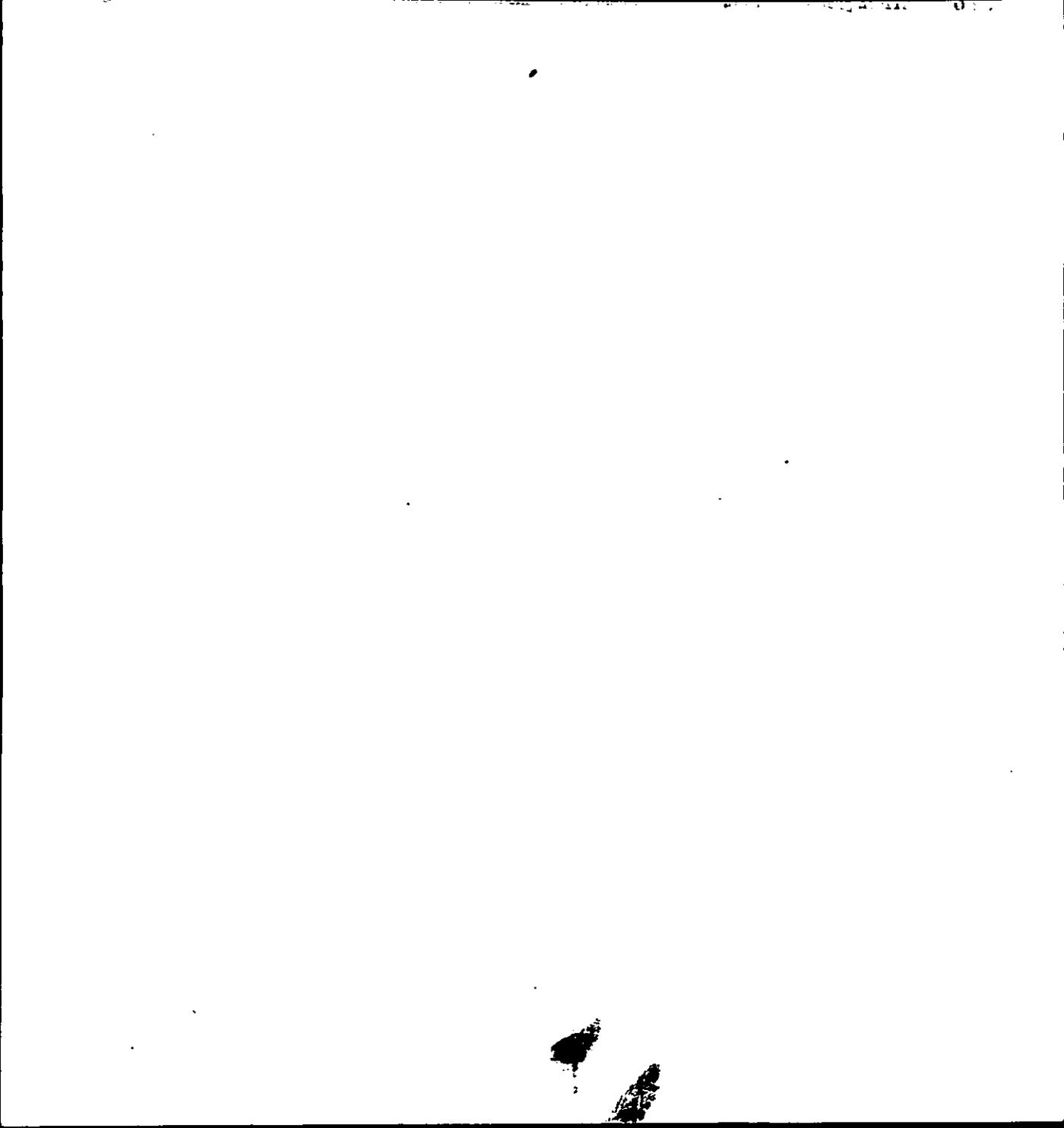
9 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS: _____
 (Signed) F. N. Saville, M. D.
 , 19 (Address) Flourtown 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 Alder Cemetery DATE OF BURIAL Dec 4 1928

20. UNDERTAKER R. A. Joseph ADDRESS 3149



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Johnson
City Johnson (No.)

Registration District No. 403
Primary Registration District No. 5932

File No.
Registered No. 24
St. Ward)

2. FULL NAME

Hellen M. Overton

(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) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 5 8

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. File Jan 18, 1929 D. Keenins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.
PRIMARY
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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

CAUSE OF DEATH IN GREEN INK TO BE PROPERTY OF REGISTRAR. STATEMENT OF OCCURRENCE IS VERY IMPORTANT.

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