

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

Do not use this space.

190

1. PLACE OF DEATH

County Boone
Township Cedar
City Ashland Mo (No.)

Registration District No. 71
Primary Registration District No. 5110 A

File No.
Registered No. 6 (Ward)

2. FULL NAME

Margaret Elizabeth Herron
(a) Residence. No. Cultrier mo 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 (or) WIFE OF Wm E. Herron

6. DATE OF BIRTH (MONTH, DAY AND YEAR) X 29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, --- hrs. or --- min.
67 2 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm wife
(b) General nature of industry, business, or establishment in which employed (or employee) ✓
(c) Name of employer

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

10. NAME OF FATHER Wm Moreau

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

12. MAIDEN NAME OF MOTHER Sue Ann

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

14. INFORMANT Warren Herron (Address) Ashland mo

15. FILED Mar 9, 1929 Ar. J. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1929

17. I HEREBY CERTIFY That I attended deceased from Jan 4, 1929, to Jan 10, 1929 that I last saw her alive on Jan 9, 1929, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
107 A
100 W
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 clinical
(Signed) H. B. Pugh Jr, M. D.
1-10, 1929 (Address) Ashland 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 Millers Creek Ch DATE OF BURIAL 1/10 1929

20. UNDERTAKER Roll Wilcox ADDRESS Columbia

M. 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.

1929
21
10

23
2
31

State: blue:
Date: 10/10/00

Y

Y

one set of documents submitted to the
Department of Justice, Office of the Inspector General
on 10/10/00. The documents are copies of the HTAB

HTAB

**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 Boone
Township Cedar
City..... (No..... St..... Ward)

Registration District No. 71
Primary Registration District No. 51109

File No.....
Registered No. 6

2. FULL NAME

Margaret Elizabeth Herron

(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) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-11-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 2 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration)..... yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration)..... yrs. mos. ds.
(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 April 10, 1929 A. J. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1929

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

20. UNDERTAKER ADDRESS

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

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SUPPLEMENTARY

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