

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

Do not use this space.

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1. PLACE OF DEATH
County Clark Registration District No. 189
Township Vernon Primary Registration District No. 523
City Alexandria (No.) St. Ward

2. FULL NAME Mrs Harrett Cloward
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 11 13

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) Clark Co Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER David Lewis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rosanna Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Mrs Dallman
(Address) Saw city Ia

15. FILED Jan 7 1929 F.A.S. Rebo and
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1929

17. I HEREBY CERTIFY That I attended deceased from Dec 28 1928 to Jan 7 1929
that I last saw her alive on Jan 9 1929, and that death occurred, on the date stated above, at 3.21 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

118 Bronchial Pneumonia
107A

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH,

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) F.A.S. Rebo, M. D.
, 19 (Address) Alexandria 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

Evangel 1-9 1929

20. UNDERTAKER W.F. Kitch ADDRESS Wayland

EXACTLY. PHYSICIANS should be stated. Exact statement of OCCUPATION is very important.

JAN 22 1929

70-1-1-13

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**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 Clatsop Registration District No. 189 File No.
 Township Vernon Primary Registration District No. 5263 Registered No.
 City (No.) St. Ward

2. FULL NAME Harratt Clinard
 (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 W
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/24/1858

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

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/7/29

17. I HEREBY CERTIFY That I attended deceased from 19....., 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:
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. ds.

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 5, 1929 Fraser & Co. Inc. REGISTRAR

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

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

DEPARTMENT RECORD

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