

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.

MAR 22 1929

235

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

Do not use this space.

Route
1380

1. PLACE OF DEATH

County Jackson
Township East a Bar
City Blue Springs (No. _____)

Registration District No. 375
Primary Registration District No. 4232

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. R.F.D. St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1.8 yrs. 9 mos. 20 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 9 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
68 9 20

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Jackson Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Thompson

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

12. MAIDEN NAME OF MOTHER Ramphell

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

14. INFORMANT Bertie Scarborough
(Address) "

15. FILED 3/12/29 F. W. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-29 1929

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to June 28, 1929, that I last saw him alive on June 28, 1929, and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
99 A
103 A
(duration) yrs. mos. 4 da.

CONTRIBUTORY Aortic Stenosis
(SECONDARY)
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, At place of death

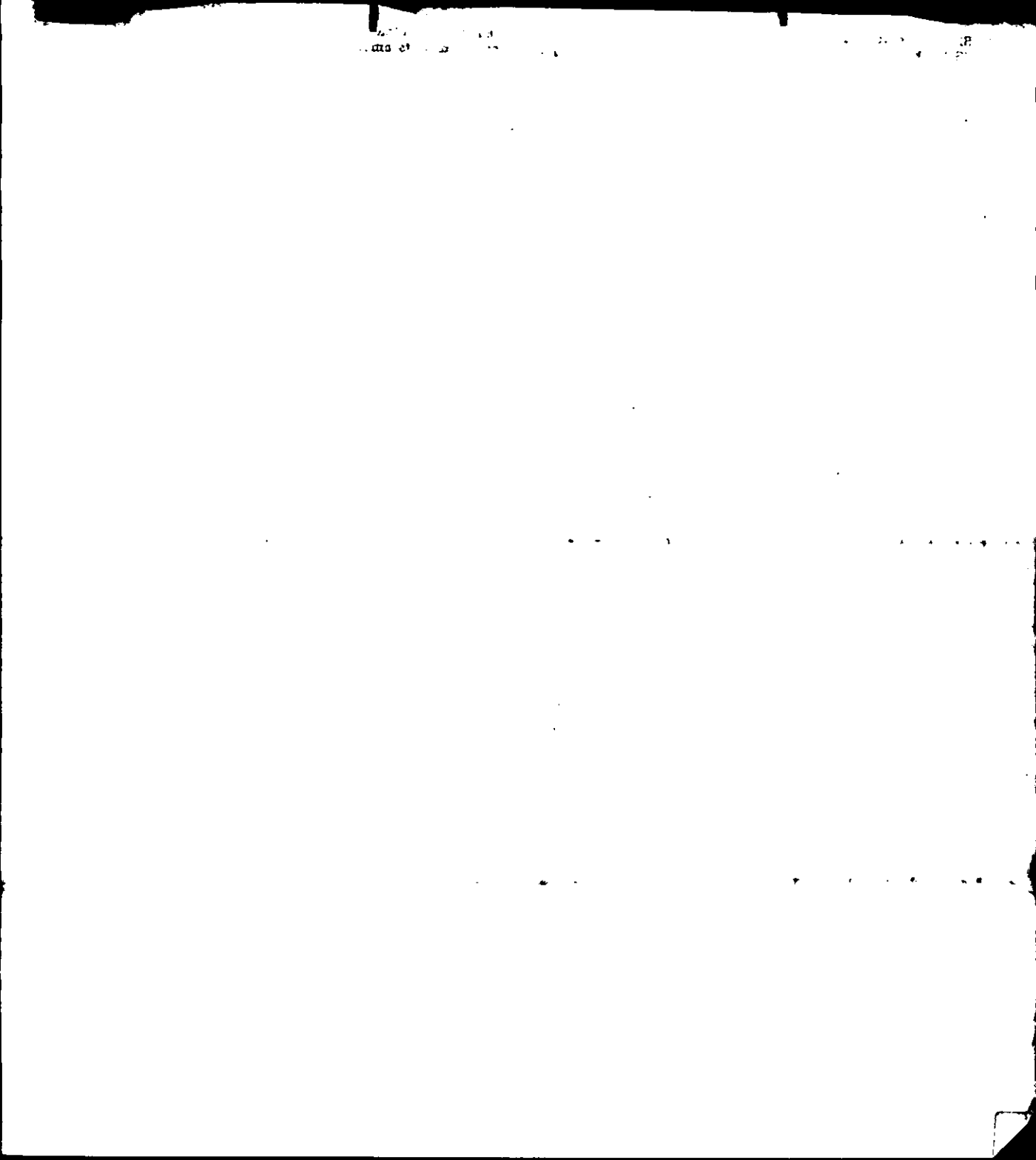
DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Physical signs
(Signed) W. G. Towns, M. D.
19 (Address) Blue Springs, 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 Blue Springs DATE OF BURIAL 1-30 1929

20. UNDERTAKER W. G. Towns ADDRESS Blue Springs



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 Jackson

Registration District No. 395-

File No.

Township Blue Spring

Primary Registration District No. 4222

Registered No.

City Blue Spring

(No.) St. Ward)

2. FULL NAME

(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) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 9 - 1880

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

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 9/13/1929 F. N. Little REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 19 29

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

Pneumonia Broncho

CONTRIBUTORY (SECONDARY) Artic Stenosis

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) W. J. Brown 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

19

SUPPLEMENTARY

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.

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

5-1380