

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

Do not use this space.

1434

1. PLACE OF DEATH

County Jackson
Township Ross
City N.C. Mo.

399

Registration District No. 1002
Primary Registration District No. 1002

File No. 21
Registered No. 21
St. Charlotte St. Ward 3

2. FULL NAME

Lucie G. McVay
(a) Residence. No. 2759 Charlotte St. Ward 3
(Usual place of abode)

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

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

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

June 25 - 1871

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

57

6

6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(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)

Illinois

10. NAME OF FATHER

Peter Daily

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

12. MAIDEN NAME OF MOTHER

No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

No Record

14.

INFORMANT

(Address)

W. E. Anderson
2759 Charlotte St.

15.

FILED

Jan 3, 1929
M. M. Crevier
Assn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan - 1 - 1929

17.

I HEREBY CERTIFY, That I attended deceased from August 15, 1928, to Dec 27, 1928

that I last saw him alive on Dec 27, 1928, and that death occurred, on the date stated above, at 6:45 PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infarct of the heart from coronary artery disease - 46C
abruptly
(duration) 1 yrs. 1 mo. 1 ds.

CONTRIBUTORY (SECONDARY)

Quarantine
(duration) 2 yrs. 2 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1. DID AN OPERATION PRECEDE DEATH?

DATE OF operation

WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

L. S. Paul, M. D.

Jan 1, 1929 (Address) 1801 15th St. B.C. B.C.

*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

Elmwood Jan 3, 1929

20. UNDERTAKER

ADDRESS

Mrs. L. T. Foster N.C. Mo.

IS A PERMANENT RECORD. It should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. in plain terms, not in technical language.

48
10
9

262
2

2

31

No. 4238
1000 156 No. 5026

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.

REGISTRATION DISTRICTS ARE COMPLETE AS PRESCRIBED BY LAW

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.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 21

City.....

(No.)

St.

Ward)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

St.

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

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)

wid

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

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

June 25-1871

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

1/3 29

M. M. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 1 1929

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw him, alive on, 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Metastatic Carcinoma from colon involving right shoulder and abdominal cavity

CONTRIBUTORY (SECONDARY)

General asthma

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

S-1434