JAN 25 1929

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

Do not use this space. 2660 ~~41818~~

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1. PLACE OF DEATH

County New Madrid — Registration District No. 604 — File No. 5

Township " " " — Primary Registration District No. 5500 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Henrietta Sloan

(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: 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: Elliot Sloan

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug-2 1865

7. AGE: Years 63 | Months 5 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: His wife
(b) General nature of industry, business, or establishment in which employed (or employer): /
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): New Madrid
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Sam Willis
11. BIRTHPLACE OF FATHER (CITY OR TOWN): New Madrid Co.
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Texana Lemond
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): New Madrid
(STATE OR COUNTRY): Mo

14. INFORMANT: Tucker Sloan
(Address): Marston

15. FILED 1/8/1929 W O Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 7, 1929, that I last saw her alive on Jan 7, 1929, and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A Influenza,
12A

11A (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY): Bronchio Pneumonia
(duration) ..... yrs. ..... mos. 5 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? no

(Signed) Claude McKinney, M. D
1/8/1929 (Address) Marston, 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: New Hope, Tenn. — DATE OF BURIAL: 1-8 1929

20. UNDERTAKER: Richards and Co. — ADDRESS: ✓

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.

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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 New Madrid Registration District No. 604 File No. 5
Township " " Primary Registration District No. 5802 Registered No.
City (No. St. Ward)

2. FULL NAME Henrietta Sloas
(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) 8/2/1865

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
63	5	5	

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)

PARENTS
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 1/8/ 1929 W. O. Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/7 1929

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

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 Richards Und Co | ADDRESS New Madrid

SUPPLEMENTARY

...information ... supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... in plain term... properly classified. Exact statement of OCCUPATION is very important.
... RECEIVE A FEE ... CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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