JAN 25 1929

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

Do not use this space. 2661

~~41834~~

File No. 7

Registered No.

1. PLACE OF DEATH
County New Madrid — Registration District No. 604
Township " " " — Primary Registration District No. 5802
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Mary Priester

(a) Residence. No. 7 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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-23-1904

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	3	15	

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

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

PARENTS
10. NAME OF FATHER Sam Nelson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Tillie Turner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Tenn

14. INFORMANT Wm. Priester
(Address) Kennett, Mo

15. FILED 1/9/ 1929 W. H. Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-8th 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 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary
(Pulmonary)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) 31
..... (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) W. H. Bannon, M. D.
1/9, 1929 (Address) New Madrid 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
Minn. Cem	1-9-1929
20. UNDERTAKER	**ADDRESS**
Richards Und. Co	New Madrid