FEB 23 1929

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

Do not use this space.

2751

1. PLACE OF DEATH
County Nodaway
Township Polk
City Maryville (No. ..... St. ..... Ward)
Registration District No. 625
Primary Registration District No. 5827
File No. .....
Registered No. 5

2. FULL NAME Minnie C Gates

(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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DEC. 29 1850

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
88	0	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Jones Co Iowa

PARENTS
10. NAME OF FATHER John Moore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Mrs C A Sewell
(Address) Graham Mo

15. FILED Jan 9, 1929 C. P. Fryer E. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1928 to Jan 3, 1929 that I last saw her alive on Jan 2, 1929, and that death occurred, on the date stated above, at 2-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107A
95B
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Dilated Heart
(duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 8
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) K C Cummings 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: Oak Hill Cemetery
DATE OF BURIAL: Jan 8 1929

20. UNDERTAKER: Price Fur Co
ADDRESS: Maryville Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified ... item of information should be carefully supplied. ... should state ... is very important.

74
0
0
235
2
31
31

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 Nodaway — Registration District No. 625 — File No.
Township Polk — Primary Registration District No. 5827 — Registered No. 5
City (No. St. Ward)

2. FULL NAME Minnie C Yates
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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 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)

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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Jan 9, 1929 — C. P. Fryer, E. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 3 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 — ADDRESS

SUPPLEMENTARY

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.

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

S-2751