

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

Do not use this space.

mlch 2570

1. PLACE OF DEATH

County Pettis Registration District No. 668 File No. _____
 Township Ludlow Primary Registration District No. 3032 Registered No. 17
 City Ludlow (No. St. Mary Hospital) 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 5 - 1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>31</u>	<u>2</u>	<u>6</u>	

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) MO

PARENTS

10. NAME OF FATHER J A Woody

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

12. MAIDEN NAME OF MOTHER Elizabeth Precker

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

14. INFORMANT O. F. Schreck (Address) Ludlow Mo

15. FILED 1-19-29 19. 29 REGISTRAR J. G. Love

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Exhaustion from hemorrhage due to fibroid of uterus
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) exhaustion from fibroids
leukemia (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? Y DATE OF Jan 9, 29

WAS THERE AN AUTOPSY? Y

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. G. Love, M. D.

(Address) Ludlow 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 _____

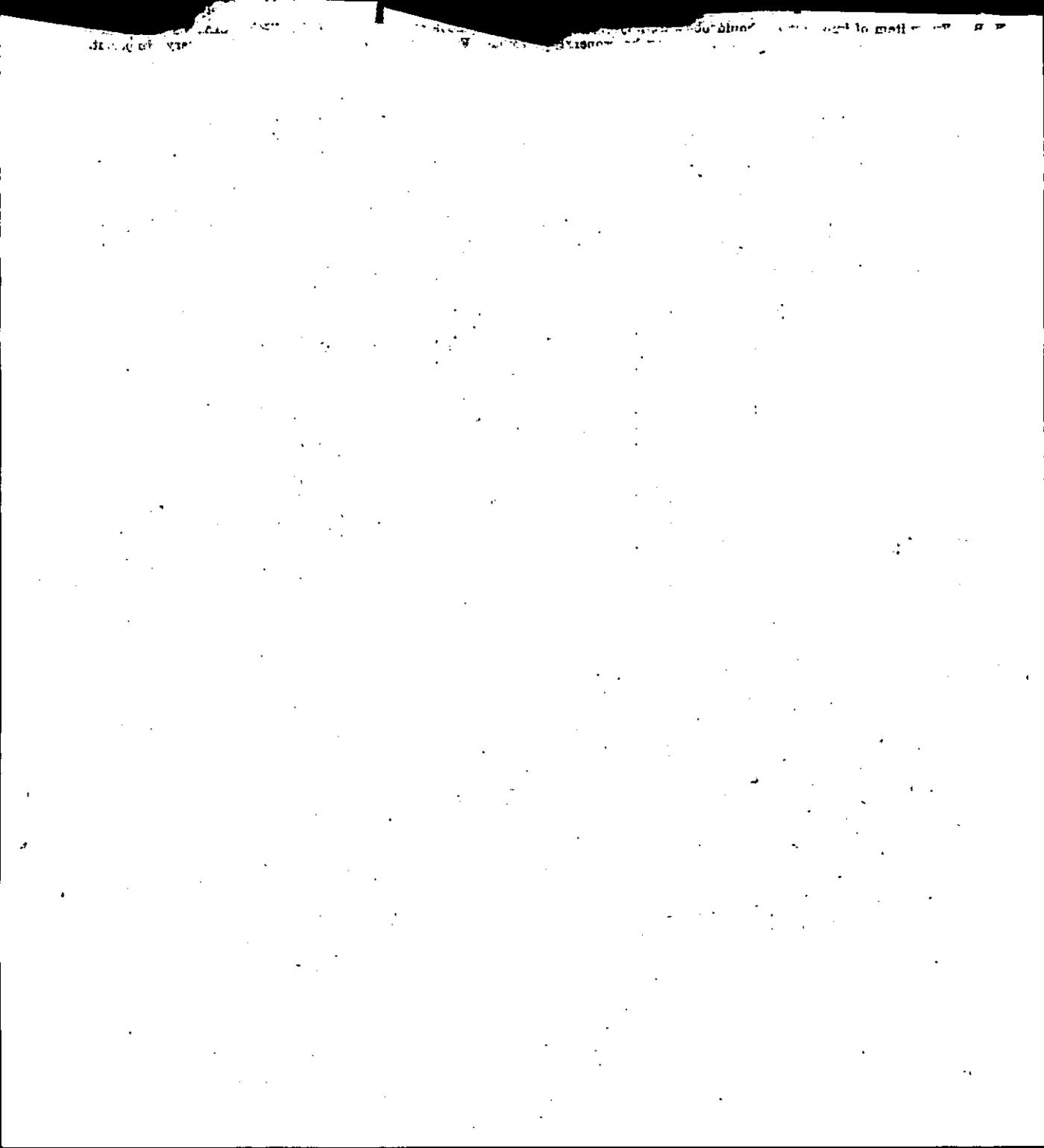
20. UNDERTAKER Juliepie ADDRESS Ludlow

N. B.—Every item of information should be stated EXACTLY. PHYSICIAN's stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly understood.

1929

235

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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 Pettis
Township Delucia
City Delucia (No.)

Registration District No. 668
Primary Registration District No. 3032

File No.
Registered No. 17
St. Ward)

2. FULL NAME

Regina Schreck

(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)

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 1-19-29

J. S. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 11 1929

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Exhaustion from hemorrhage due to fibroid of uterus
CONTRIBUTORY (SECONDARY) non-malignant

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

20. UNDERTAKER

ADDRESS

19

N. B.—Every item of information should be recorded EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-2870