

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

Do not use this space.

5072

1. PLACE OF DEATH

County Stoddard
Township Castor
City..... (No..... Ward)

Registration District No. 837
Primary Registration District No. 6099

File No.....
Registered No.....
St..... Ward

2. FULL NAME

Rose Mary Perry

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-2-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
		<u>9</u>	<u>9</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) Stoddard Co. Mo

10. NAME OF FATHER Elvis Perry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Stod Co. Mo.

12. MAIDEN NAME OF MOTHER Vernie Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Stod Co. Mo.

14. INFORMANT (Address) Maurice Allen Bloomfield Mo.

15. FILED Jan 29 1929 Edward Ford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-11 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1929, to Jan 11 1929, that I last saw her alive on Jan 10 1929, and that death occurred, on the date stated above, at 9 o'clock a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia
11A
107A

(duration) yrs. mos. 7 da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. H. Smith M. D.

, 19 (Address) Bloomfield Mo

*State the DISEASE CAUSING DEATH, or if death 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

Walters Cemetery

1-12 1928

20. UNDERTAKER

ADDRESS

J. A. Shilt Bloomfield

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.

103

000

PARENTS

**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 Stoddard
Township Castor
City..... (No.....)..... St. Ward)

Registration District No. 837
Primary Registration District No. 6099

File No.
Registered No.
St. Ward)

2. FULL NAME

Rose Mary Dewey

(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 S
(write the word)

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

Jan 11 1929 Edward Ford
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....., and that I last saw h..... at....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchitis - Pneumonia
Followed by influenza

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

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

SUPPLEMENTARY

N. B.—Every item of information stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important. AGE properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-5078