

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

Do not use this space.

6007

1. PLACE OF DEATH
 County Dunklin Registration District No. 282
 Township Campbell Primary Registration District No. 4166
 City _____ (No. _____) (If nonresident give city or town and State)
 2. FULL NAME Margaret A. Brown
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 - 27 0 hrs. 0 min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House Keeper
 (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) Ill

10. NAME OF FATHER Isaac Blackard

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

12. MAIDEN NAME OF MOTHER Caroline Davis

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

14. INFORMANT Georgia Tate
 (Address) Campbell

15. FILED 2/13, 1929 W. Sanders
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 4, 1929 to Feb 12, 1929 that I last saw her alive on Feb 4, 1929, and that death occurred, on the date stated above, at 27 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
IB
 (duration) yrs. mos. da. _____

CONTRIBUTORY (SECONDARY) IB
 (duration) yrs. mos. da. _____

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?
 (Signed) W. Sanders, M. D.
 , 19 (Address) Campbell, 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 Four Mile Cem DATE OF BURIAL 2/13 1929

20. UNDERTAKER W. Sanders ADDRESS Campbell

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAR 21 1929

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