

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

Do not use this space.

6282

1. PLACE OF DEATH

County Harrison Registration District No. 380 File No. _____
 Township _____ Primary Registration District No. 4224 Registered No. 7
 City New Franklin St. _____ Ward _____

2. FULL NAME

Bessie L Cross
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. 62 new long in U.S., if of foreign birth? 62 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Geo Cross
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 - 64
 7. AGE YEARS MONTHS DAYS 23 IF LESS than 1 day, hrs. or min.
64 5 23

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-16 1929
 17. I HEREBY CERTIFY, That I attended deceased from 2-2-1929 to 2-16-1929, 1929 that I last saw her alive on 2-15-1929, and that death occurred, on the date stated above, at 11:50 p.m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
11A
109 (duration) yrs. mos. 7 da.
 CONTRIBUTORY Influenza
 (SECONDARY) (duration) yrs. mos. 14 da.

9. BIRTHPLACE (CITY OR TOWN) Connell Co
 (STATE OR COUNTRY) England

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.
HA
 18 DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? _____

10. NAME OF FATHER Thos Mac Reis

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) B. Fleet M. D.
2-18-1929 (Address) New Franklin Mo

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

12. MAIDEN NAME OF MOTHER Janie Montgomery

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

14. INFORMANT Geo Cross
 (Address) Radio 7 Franklin Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Franklin Mo DATE OF BURIAL 2-19 19

15. FILED 2-18-29 B. Fleet REGISTRAR

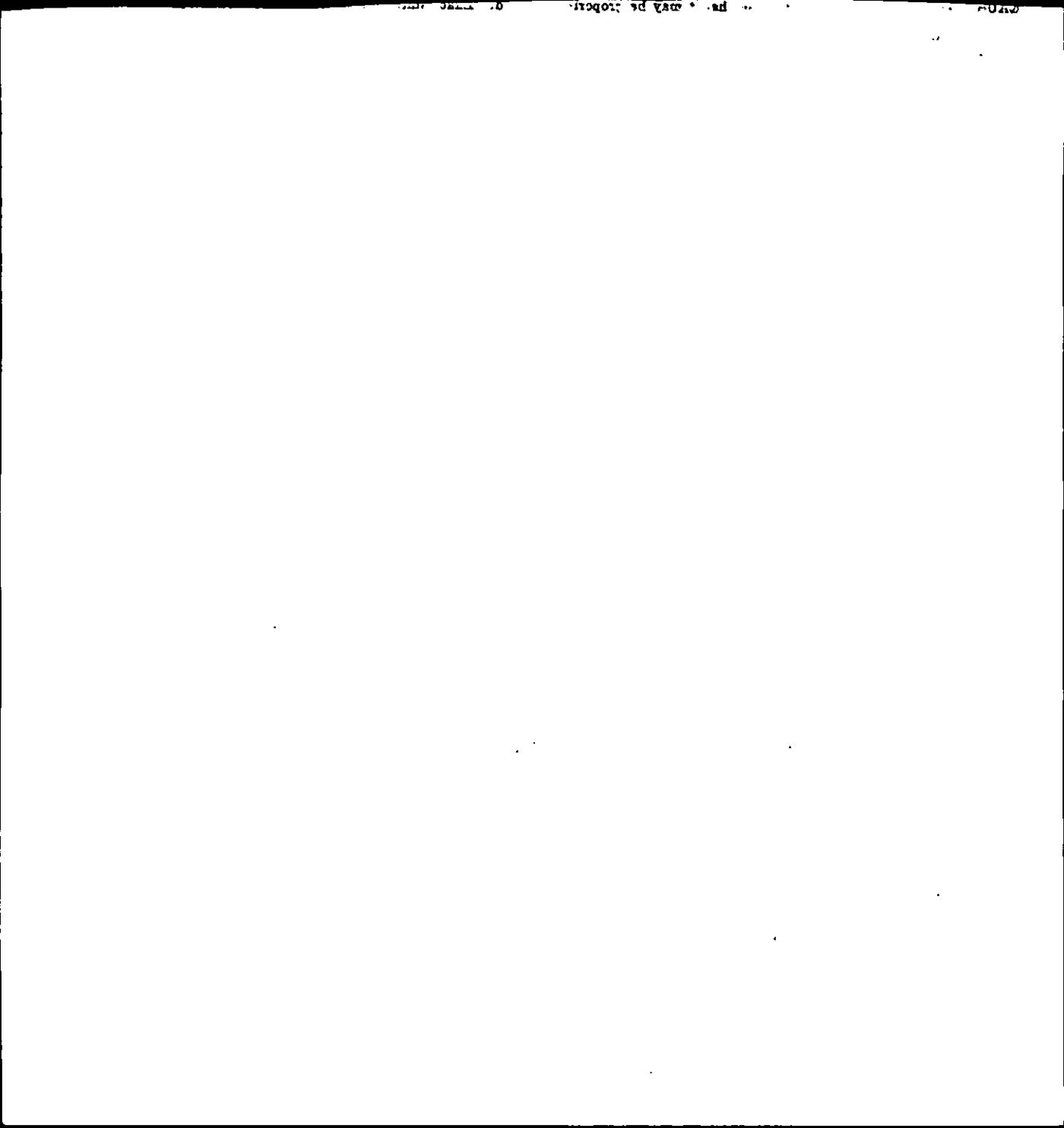
20. UNDERTAKER Edison Co New Franklin Mo ADDRESS

MAR 22 1929

235

8

48



**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 Howard Registration District No. 380 File No. _____
 Township _____ Primary Registration District No. 4224 Registered No. 7
 City New Franklin (No. _____) 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

MEDICAL CERTIFICATE OF DEATH

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

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

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

CONTRIBUTORY (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

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) _____

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) _____

*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.

14. INFORMANT (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 2-17, 1929 B. B. Blesh REGISTRAR

20. UNDERTAKER ADDRESS _____

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

SUPPLEMENTARY

5-6282