

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

Do not use this space.

7760

PLACE OF DEATH
 County St. Clair
 Township Palmyra
 City (No.) (St.) (Ward)

Registration District No. 1037
 Primary Registration District No. 6013

File No. 2
 Registered No. 1

2. FULL NAME Mrs A M Drury (Drury)
 (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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A M Drury
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 74
 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)

9. BIRTHPLACE (CITY OR TOWN; (STATE OR COUNTRY) Young
 10. NAME OF FATHER Don't know
 11. BIRTHPLACE OF FATHER (CITY OR TOWN; (STATE OR COUNTRY) Don't know
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN; (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs Wheeler
 (Address) Osceola Mo
 15. FILED 3/15 29 L Garrison REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13th 19 29
 17. I HEREBY CERTIFY, That I attended deceased from Feb 12th 1929, to Feb 13th 19 29 that I last saw her alive on Feb 13 19 29, and that death occurred, on the date stated above, at 10.10 P.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
113
1137 Failure and asthenia
due to age
 (duration) yrs. mos. ds.
 CONTRIBUTORY Myocardial degeneration
 (SECONDARY) of heart
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) E. J. Dulcish, M. D.
2/14 1929 (Address) Osceola 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 Kings Prairie DATE OF BURIAL 2-15 19 29
 20. UNDERTAKER O S Hull ADDRESS

35
 2
 11

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Clair Registration District No. 1037 File No.
 Township York Primary Registration District No. Registered No. 1
 City..... (No.) St. Ward)

2. FULL NAME

Mrs. P. M. Drury
 (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. ormin.

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 Feb 13 1929 L. Garrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 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

20. UNDERTAKER A. S. Hull ADDRESS Osceola

SUPPLEMENTARY

S-776D

OFFICE REPORT

REPORT NO. 1000

DATE

BY

REASON

DESCRIPTION

REMARKS

CONCLUSION

APPROVED

SIGNATURE

DATE