

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

Do not use this space.

9967

24 1929

1. PLACE OF DEATH
 County Clay Registration District No. 148
 Township Light Primary Registration District No. 3011
 City Excelsior Springs St. _____ Ward _____

2. FULL NAME Bertha May Camden
 (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 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. _____
 Registered No. 37

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
18

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work School Girl
 (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) Missouri

10. NAME OF FATHER Geo. Motor Camden

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

12. MAIDEN NAME OF MOTHER Virginia Werner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ray, Mo. (STATE OR COUNTRY) Missouri

14. INFORMANT Geo. M. Camden (Address) Excelsior Springs, Mo.

15. FILED 3-21-29 Yd. Craven REGISTRAR

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Mar 21, 1929, that I last saw h. alive on Mar 20, 1929, and that death occurred, on the date stated above, at 8:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis (Pulmonary type)
Influenza
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED?
 IF NOT AT PLACE OF DEATH: at penitent.
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? physical findings
 (Signed) Samuel R. M. ..., M. D.
 , 19 _____ (Address) Excelsior Springs 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 Mar. 22 19 29

20. UNDERTAKER Herbert Hope ADDRESS Excelsior Springs Mo

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.

261

100

100