

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

Do not use this space.

10797
1306

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Law Primary Registration District No. 1002
City Wagon, Mo (No. General Hosp # 2)

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 905 Tracy Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 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 Colored 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) Oct. 23, 1913

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>15</u>	<u>4</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. General Nurse
(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) Mo.

10. NAME OF FATHER Stewart, Wm.

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

12. MAIDEN NAME OF MOTHER Mary Gains

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

14. INFORMANT Patent herself (Address) 905 Tracy

15. FILED 3/15, 1929 M. M. G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-12-1929

17. I HEREBY CERTIFY, That I attended deceased from 3-12-1929 to 3-12-1929 that I last saw her alive on 3-12-1929 and that death occurred, on the date stated above, at 3:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED At Home
IF NOT AT PLACE OF DEATH. _____

1 DID AN OPERATION PRECEDE DEATH No DATE OF 3-12-29

WAS THERE AN AUTOPSY? No

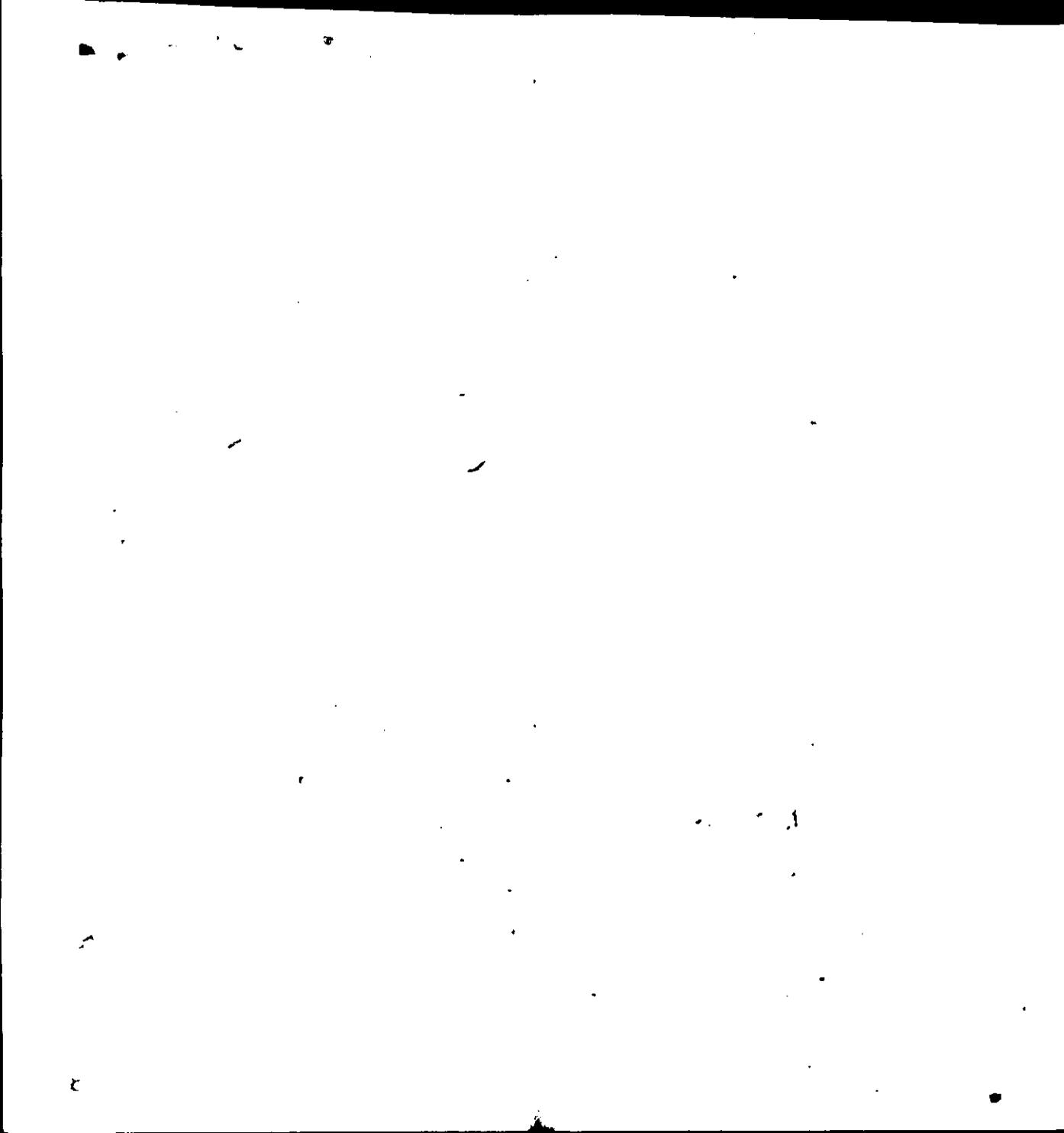
WHAT TEST CONFIRMED DIAGNOSIS Microscopic

(Signed) Supt. W. M. Smith
3/13, 1929 (Address) General Hospital

*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 Marshall Mo DATE OF BURIAL 3-15-1929

20. UNDERTAKER H. B. Moore ADDRESS 1820 E 18th



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No.
 Township Law Primary Registration District No. 1072 Registered No. 1306
 City Kennett (No. General Hospital) St. Ward

2. FULL NAME

Wilma Stewart
 (a) Residence No. 1905 Tracy 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 Leal 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
15 4 19

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 3/15 29 M. M. Cronin REGISTRAR
 1929

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/12 1929
 17. I HEREBY CERTIFY, That I attended deceased from
 that I last saw him alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:
Generalized Peritonitis
Typhoid fever
Wound caused infection
non typhoid
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? yes DATE OF 3-12-29
 WAS THERE AN AUTOPSY?
 WHAT WERE THE CONFIRMED DIAGNOSIS?
 (Signed) W. H. O., 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

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

SUPPLEMENTARY

S-10797