

30 1929

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

Do not use this space.

11926

1. PLACE OF DEATH

County Polk
Township Larry
City Carroll (No.) St. Ward)

Registration District No. 716
Primary Registration District No. 5945

File No.
Registered No. 11

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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 19 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 11 29

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) General Household
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lanshan Co Mo.

10. NAME OF FATHER William Ray

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

12. MAIDEN NAME OF MOTHER Harriet Kent

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

14. INFORMANT (Address) Arthur Rose
Carroll Mo.

15. FILED 3/29/29 H. Sell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28 1929

17. I HEREBY CERTIFY That I attended deceased from Dec 27, 1928 to March 28, 1929 (that I last saw him alive on March 27, 1929, and that death occurred, on the date stated above, at 8 a.m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intermittent Fever
550
(duration) 2 yrs. 0 mos. 0 da.

CONTRIBUTORY (SECONDARY) unknown
(duration) — yrs. — mos. — da.

18. WHERE WAS DISEASE CONTRACTED Place of Death
IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Rapid Examination
(Signed) H. Sell M. D.
3/29, 1929 (Address) Carroll 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 Coates Cemetery DATE OF BURIAL 3/29 1929

20. UNDERTAKER Paul Hoops ADDRESS Carroll 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.

85
1
3

289

**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 Oulaski
Township Tavern
City..... (No..... St..... Ward)

Registration District No. 7/6
Primary Registration District No. 3-945-

File No.....
Registered No. 11
St..... Ward)

2. FULL NAME

Mary E Rose

(a) Residence. No..... St..... Ward.....
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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 3/19/29 M. E. Sell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 28 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:

Intra-cranial Tumor
Malignant
..... (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

ADDRESS

Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is required. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-11926