

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

Do not use this space.

1929

13500

**1. PLACE OF DEATH**

County Jett  
Township Richland  
City Richland (No.         )

Registration District No. 827  
Primary Registration District No. 6070

File No. 39  
Registered No.           
St.          Ward         

**2. FULL NAME**

Louise Childs

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**2 MEDICAL CERTIFICATE OF DEATH**

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  
X X X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-21-1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
         10          22         

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work X X X  
(b) General nature of industry, business, or establishment in which employed (or employer)           
(c) Name of employer         

9. BIRTHPLACE (CITY OR TOWN) Ark.  
(STATE OR COUNTRY)

10. NAME OF FATHER J. C. Childs

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

12. MAIDEN NAME OF MOTHER Opal Hall

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

14. INFORMANT Frank Hall  
(Address) New Madrid, Mo.

15. FILED 4/30/29 Walter E. Ellis  
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-13 1929

17. I HEREBY CERTIFY That I attended deceased from 3-13 1929, to 3-13 1929, that I last saw him alive on 3-13 1929, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: 1191  
Congestion  
of Stomach & Bowels  
(duration) yrs. mos. da.

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

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

19. DID AN OPERATION PRECEDE DEATH?          DATE OF           
WAS THERE AN AUTOPSY?         

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. H. Waters M. D.  
, 1929 (Address) Sikeston, 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 Evergreen Cem. DATE OF BURIAL 3-14 1929

20. UNDERTAKER Richardson Lnd. Co. ADDRESS New Madrid

2  
7  
2



BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

FOR MUST BE WRITTEN  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott Registration District No. 821 File No. \_\_\_\_\_  
 Township Richland Primary Registration District No. 6070 Registered No. 37  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Louise Childa

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

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 4/10/29 Walter E. Denis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/13 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:

Constitution  
Stomach & bowels  
 \_\_\_\_\_  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY)

Colitis  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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 \_\_\_\_\_

SUPPLEMENTARY

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-13500

