

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

Do not use this space.

13876

1. PLACE OF DEATH

County Buchanan
Towship St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. State Hospital #2)

File No. _____
Registered No. 453
St. _____ Ward _____

2. FULL NAME

Olivia Roy
(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 7 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18 82

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 Unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(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) U.S.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT C.C. Anderson
Address State Hosp. #2

15. FILED APR 4 1939 REGISTRAR John G. [Signature]

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-2-1939

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1929 to April 2nd 1939, and that I last saw her alive on April 2nd 1939, and that death occurred, on the date stated above, at 2:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
Syphilis & Vincent's Angina
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) C. Dewey, M. D.
4/4, 1939 State Hosp. #2

*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 State Hospital No 2 DATE OF BURIAL Apr 4-1939

20. UNDERTAKER B. F. Graves ADDRESS 806 S. 11th St

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.

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DEPARTMENT RECORD

