

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

Do not use this space.

14076
Final

231929

1. PLACE OF DEATH
 County Boone Registration District No. 175
 Township " Primary Registration District No. 3009
 City " (No. ") St. " Ward "

File No. "
 Registered No. 108

2. FULL NAME Mary E. Greer
 (a) Residence. No. South Kingshighway 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF "
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 22-1885
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 7 5
 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) New Madrid Mo
 10. NAME OF FATHER John Black
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
 12. MAIDEN NAME OF MOTHER Emma Black
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT Walter J. Greer
 (Address) Boone Guardian #100
 15. FILED Apr 29 1929 W. C. Kaempfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1929
 17. I HEREBY CERTIFY, That I attended deceased from 4-7-29 to 4-28-29
 that I last saw her alive on 4-27-29, and that death occurred, on the date stated above, at 3:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicaemia
 (duration) yrs. mos. 2 ds.
 CONTRIBUTORY (SECONDARY) Reason of Heart
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? NO DATE OF.....
 WAS THERE AN AUTOPSY? NO
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) [Signature] M. D.
 . 19 (Address) Boone Guardian

*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
Fairmount Cemetery Apr 29 1929
 20. UNDERTAKER ADDRESS
Walter Und. Co. Boone Guardian #100

PARENTS



**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 Cape Girardeau
Township _____
City _____ (No. _____) St. _____ Ward _____

Registration District No. 125
Primary Registration District No. 3009

File No. _____
Registered No. 108

2. FULL NAME

Mary E. Green

(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) M

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 6/11, 1929 W. Kaempfe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 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:
Septicemia

CONTRIBUTORY (SECONDARY) Abrasion from _____ (duration) yrs. mos. ds. fall
of tuler _____ (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) W. Smith M. D.
Boyle Headhead

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

S-14076

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI