

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

Do not use this space.

14511-a  
 File No. 47

**1. PLACE OF DEATH**

County Howell Registration District No. 384  
 Township West Plains Mo. Primary Registration District No. 4277  
 City West Plains Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Helen Miriam Peale  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) 4/27-1929

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of**

**17. I HEREBY CERTIFY**, That I attended deceased from 9-14-1929, to 4-27-1929, that I last saw her alive on 4-27-1929, and that death occurred, on the date stated above, at 3145-a.m.

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Oct 2-1893

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**7. AGE** YEARS MONTHS DAYS 35 0 0 0 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Chronic Carcinoma of the Cervix Uteri  
Chronic myocarditis  
 (duration) ? yrs. mos. da.  
**CONTRIBUTORY (SECONDARY)** Chronic Cholecystitis  
 (duration) ? yrs. mos. da.

**8. OCCUPATION OF DECEASED**

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

**18. WHERE WAS DISEASE CONTRACTED** At home  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

**9. BIRTHPLACE** (CITY OR TOWN) Spout Spring, Ind.  
 (STATE OR COUNTRY) Indiana

**DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**10. NAME OF FATHER** N. M. Peale

**WAS THERE AN AUTOPSY?** no

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) Waberton  
 (STATE OR COUNTRY) Indiana

**WHAT TEST CONFIRMED DIAGNOSIS:** \_\_\_\_\_  
 (Signed) E. Claude Bohrer, M. D.

**12. MAIDEN NAME OF MOTHER** Anna C. Lynch

0-3-, 1929 (Address) West Plains, Mo.

**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) Lawrence, Mo.  
 (STATE OR COUNTRY) Missouri

\*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.

**14. INFORMANT** Mrs. A. M. Peale  
 (Address) West Plains, Mo.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Oak Lawn  
**DATE OF BURIAL** 4/29 1929

**15. FILED** 5-4-1929 O. P. Heurich  
 REGISTRAR

**20. UNDERTAKER** McFarland's  
 ADDRESS West Plains, Mo.

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**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 Howell Registration District No. 384 File No. \_\_\_\_\_  
 Township West Plains Primary Registration District No. 4 227 Registered No. 47  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/27 1929  
 17. \_\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 2-1893

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
35 - 6 - 28 - 2

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

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

10. NAME OF FATHER \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

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

18. WAS THERE AN AUTOPSY? \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

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

(Signed) \_\_\_\_\_, M. D.

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

. 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.

15. FILED 5-4-29 O. A. Kinnick REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE of DEATH. Very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-14512