

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

Do not use this space.

15070

27 1929

1. PLACE OF DEATH

County Jasper Registration District No. 411 File No. 4002
 Township Malone Primary Registration District No. 409 Registered on 1.64
 City Jordan (No. 409 by Dr. Clark Ward)

2. FULL NAME Mable White

(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 Female **4. COLOR OR RACE** W. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** divorced (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edd White

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 - 1894

7. AGE YEARS MONTHS DAYS 31 last 10 14 1 LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER no record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) no record
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) no record
 (STATE OR COUNTRY)

14. INFORMANT Melbae White
 (Address) Jordan Mo.

15. FILED Feb. 29 1929 Dr. A.B. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-7-1929

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 _____, 3 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic indigestion
127 3/4
1160 Looped bowels
 CONTRIBUTORY (SECONDARY)

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

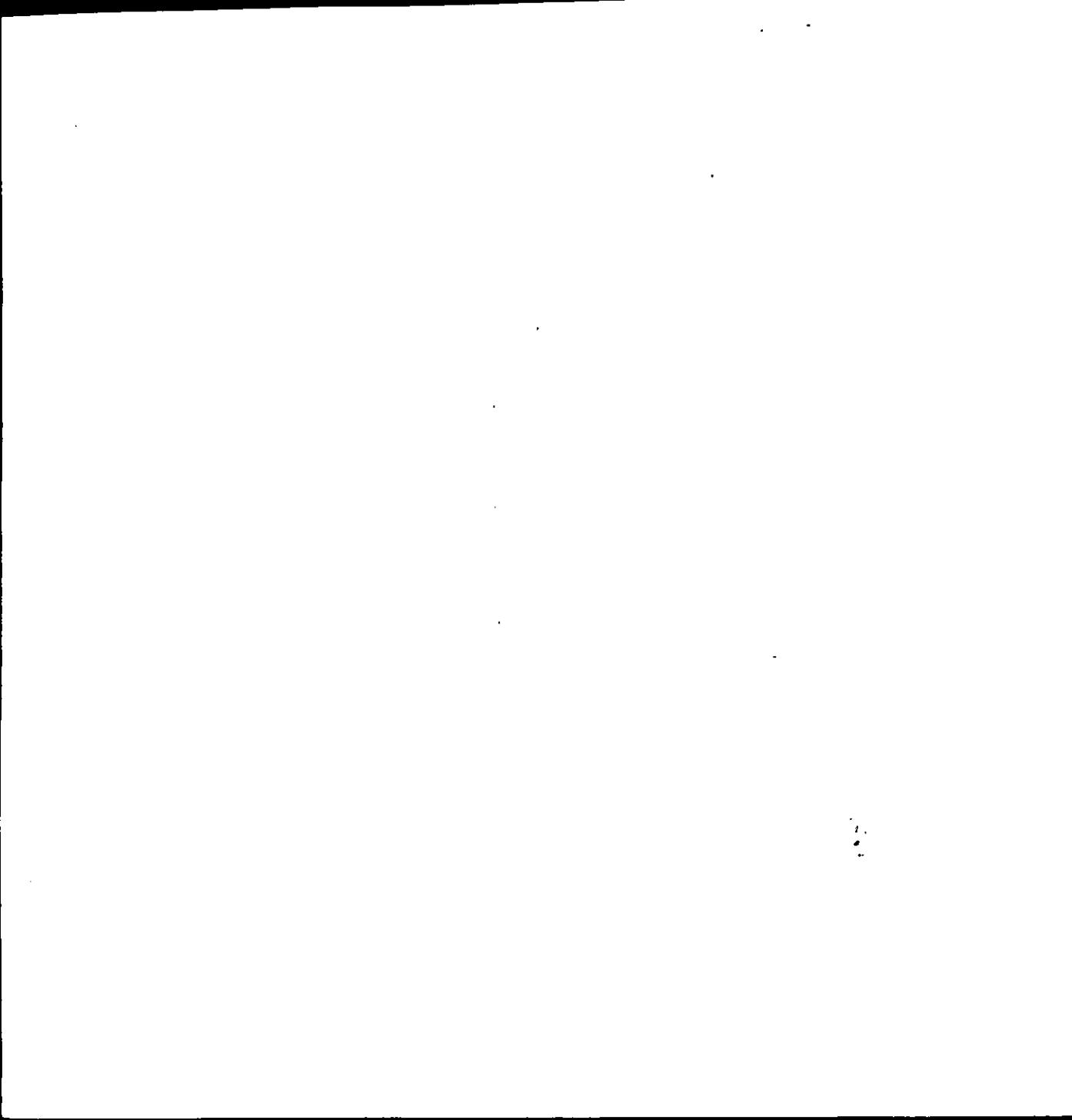
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. Snyder, M. D.
 (Address) Jordan Mo.

*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 Jordan Mo. **DATE OF BURIAL** 4-10-1929

20. UNDERTAKER W. H. Clark & Co. **ADDRESS** Jordan Mo.

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 Gasper Registration District No. 211 File No. _____
 Township _____ Primary Registration District No. 2002 Registered No. 164
 City Gaslin (No. _____) St. _____ Ward _____

2. FULL NAME

Mable White
 (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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid
(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 6/22, 29 Wmson Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/7 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:

acute indigestion
from unknown
cause
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) stomped bowels
from fecal impaction
 (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

REGISTRARS SHALL NOT REC. FILE FOR CERTIFICATED UNTIL STATE BOARD OF HEALTH

SUPPLEMENTARY

S-15000