

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

Do not use this space.

17493

1. PLACE OF DEATH  
 County CAPE GIRARDEAU Registration District No. 120  
 Township Al Precinct Registration District No. 3009  
 City CAPE GIRARDEAU MO (No. St. No Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. 128  
 2. FULL NAME MARY FLORENCE CARBAUGH  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Chaffee Mo  
 (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) WIDOWED  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ALEXANDER CARBAUGH  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) DEC 14TH 1865  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
63 5 16  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work HOUSE KEEPER  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) NEW HARMONY INDIANA  
 (STATE OR COUNTRY)  
 10. NAME OF FATHER DAVID WHITE  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) INDIANA  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER MARY F WILSEY  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) DON'T KNOW  
 (STATE OR COUNTRY)

14. INFORMANT H E Carbaugh  
 (Address) Home of self  
 15. FILED 6/1 29 W C Temple  
 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 19 29  
 17. I HEREBY CERTIFY That I attended deceased from May 28 1929, to May 30 1929, that I last saw her alive on May 30 1929, and that death occurred, on the date stated above, at 13:30 a.m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Infection of Gall bladder and acute Gastro enteritis  
12:30 B  
12:0 B (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Dr. Paul F. Williams, 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 U P CEMETARY CHAFFEE MO DATE OF BURIAL JUNE 2 19 29  
 20. UNDERTAKER H F. Stubbs ADDRESS CHAFFEE MO

16  
 24  
 2  
 8  
 33  
 2  
 2  
 31  
 N. 2. CAUSE OF DEATH TO BE STATED EXACTLY. PHYSICIANS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cape Girardeau Registration District No. 125 File No. ....  
Township ..... Primary Registration District No. 3009 Registered No. 128  
City Cape Girardeau 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**

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

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 7/13 1929 W. Haempfer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 - 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:**

Infection of gall bladder and acute pasty enteritis  
Cholera Cystitis  
(duration) yrs. mos. ds.

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)....., 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

19

**SUPPLEMENTARY**

124 B

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, or that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL RECEIVE A FEE OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

EBHLS