

27 1929

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

Do not use this space.

19142

1. PLACE OF DEATH

County Boyer
Township Boyer
City Boyer

Registration District No. 742
Primary Registration District No. 5-977a

File No.
Registered No. 5
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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2-1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 54 3 1

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. House keeping
(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) No

10. NAME OF FATHER Wm W Rippy

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

12. MAIDEN NAME OF MOTHER Elizabeth Stephenson

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

14. INFORMANT (Address) Jas K. Dawson

15. FILED 6-2-29 Edwin Shouse REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3 1929
17.

I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to May 3, 1929 that I last saw her alive on May 3, 1929, and that death occurred, on the date stated above, at Boyer, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright's disease of kidneys (duration) 2 yrs. mos. da.
CONTRIBUTORY (SECONDARY) high blood pressure
Paralysis (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) Place of death

19. DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS (Signed) W. E. Baker M. D.
Jawson, 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 Jawson Mo May 5 1929

20. UNDERTAKER ADDRESS J. M. Ward Jawson

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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 Ray Registration District No. 742 File No. 1-
Township York Primary Registration District No. 5977a Registered No. 3-
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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(If divorced, give 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) Edwin House

15. FILED 19 Edwin House REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright's disease of kidneys
General paralysis from
poison of 3 fluid coma
CONTRIBUTORY (SECONDARY) light blood Press.
Paralysis (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. J. Galt, M. D.

, 19 (Address) Lawson

*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

RECIPIENTS SHALL NOT RECEIVE A FEE FOR CERTIFICATES. COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-19142