20 1929

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

Do not use this space.

19200

1. PLACE OF DEATH
County St Francois — Registration District No. 773 — File No.
Township — Primary Registration District No. 4464 — Registered No. 84
City Farmington (No. ..... St. ..... Ward)

2. FULL NAME Mrs Katie Chaney
(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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19-1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
74	9	26	

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

9. BIRTHPLACE (CITY OR TOWN) Nevada Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Rucker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT George Chaney
(Address) Farmington Mo

15. FILED 5-15, 1929 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1929

17. I HEREBY CERTIFY, That I attended deceased from May 10 hrs, 1929, to May 15, 1929 that I last saw her alive on ....., 19....., and that death occurred, on the date stated above, at 6:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

121 Paralysis
[illegible]
[illegible] (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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) Geo. L. Watkins, M.D.
5-15, 1929 (Address) Farmington 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 G.A.R. Miami Okla — DATE OF BURIAL 5/17 1929

20. UNDERTAKER Neidert Mudd Co — ADDRESS Farmington Mo

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: St. Francois Registration District No. 773 File No.
Township: Primary Registration District No. 4464 Registered No. 84
City: Farmington (No. , St. , Ward)

2. FULL NAME: Mrs Katie Chaney
(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	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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)

PARENTS
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 7-10, 1929 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 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:
Paralysis
Dr. Hoskins, me the patient died my
[illegible] from chronic nephritis
[illegible] and arterio sclerosis. Pt had shock
[illegible] and left side hemiplegia.
(duration) yrs. mos. ds.
The Certificate was probably made out
by her office nurse.
CONTRIBUTORY (SECONDARY)
July 10 29 (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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRAR SHALL NOT RECEIVE A FILE FOR CERTIFICATES OF DEATH