

JUL 24 1929

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

Do not use this space.

21118

1. PLACE OF DEATH

County Dunklin
Township Cottonhill
City near Malden (No. _____ St. _____ Ward)

Registration District No. 289
Primary Registration District No. 5407

File No. _____
Registered No. 33

2. FULL NAME

Julia May Fox

(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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28 1901

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
28 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools
(c) Name of employer Granite City School (Grays)

9. BIRTHPLACE (CITY OR TOWN) East St. Louis Ill.
(STATE OR COUNTRY) Ill. - St. Clair Co.

10. NAME OF FATHER Hugh J. Fox
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Charles Mo
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Anna Bernharter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wichita Kansas
(STATE OR COUNTRY)

14. INFORMANT H. J. Fox
(Address) Malden Mo

15. FILED 6/10 1929
Dr Mitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1929 to June 14 1929 that I last saw her alive on June 14 1929, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) 2.3A 31 (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH Granite City Ill

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Pathology
(Signed) John W. Cleve M. D.

6/16 1929 (Address) Malden 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 St Marys Cem DATE OF BURIAL 6-16 1929

20. UNDERTAKER Dr Brumby ADDRESS Capt St. Louis

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

6-29
 ALL INFORMATION CALLED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin
 Township Monticello
 City (No. _____) _____

Registration District No. 289
 Primary Registration District No. 3407

File No. _____
 Registered No. 33
 St. _____ Ward _____

2. FULL NAME

Julia May Fox

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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 6/16 1929 S. Mitchell
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14-1929

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:

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) _____, 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 _____

SUPPLEMENTARY

SHALL NOT RECEIVE A FEE FOR CERTIFICATES IN WHICH THEY ARE COMPLETED AS PRESCRIBED BY LAW
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN or local state health officer should be properly classified. Cause of death should be stated in plain terms, so that it may be understood. Exact statement of OCCUPATION is important.

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