

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

Do not use this space.

22665

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1003

Registered No. 6067

City St. Louis

(No. St. Louis Maternity Hosp St. Ward)

2. FULL NAME

Stamps, Agnes Laura

(a) Residence. No. Jerseyville, Ill. St. 12 Ward. Jerseyville Ill

(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

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Stamps, Joseph Lorenzo

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

Jan 16, 1909

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

20

4

17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Huf.

(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) Shelby Co. Ill

10. NAME OF FATHER

Thomas L. Butler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER

Ella Webb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Shelby Co. Ill

14. INFORMANT

Joseph L. Stamps
(Address) Jerseyville Ill

15. FILED

Jan -3 1929
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 21, 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-27-29

....., 19....., to 6-2-29, 19.....

that I last saw her alive on 6-2-29, 19....., and that

death occurred, on the date stated above, at 12:33 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis

121 hr
134 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Ruptured Appendix
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH, No. DATE OF

WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS?

6/1 (Signed) R.H. Powers, M. D.

12, 19 29 (Address) 630 S. Kings Highway

*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

Jerseyville Ill

DATE OF BURIAL

6/4 19 29

20. UNDERTAKER

Jacoby Bros Ind.

ADDRESS

Jerseyville Ill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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