

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

Do not use this space.

✓ 25325

1. PLACE OF DEATH

County Wade Registration District No. 605
 Township Cairo Primary Registration District No. 2804
 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-2-1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
32 4 24

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) Madison Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Howell Graves

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Madison Mo.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Cara Alley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Clariton Mo.
 (STATE OR COUNTRY)

14. INFORMANT J. J. Maloney
 (Address) Missouri

15. FILED 7/27, 1929 Mr. C. S. Slackman
By Mrs. V. B. Slackman REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-26-1929

17. I HEREBY CERTIFY, That I attended deceased from 7-15-1929 to 7-26-1929
 that I last saw him alive on 7-25-1929, and that death occurred, on the date stated above, at 2:50 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
General Septicemia

12-18
12-20
 (duration) yrs. mos. ds.

CONTRIBUTORY Abuse on hand
 (SECONDARY) (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? No

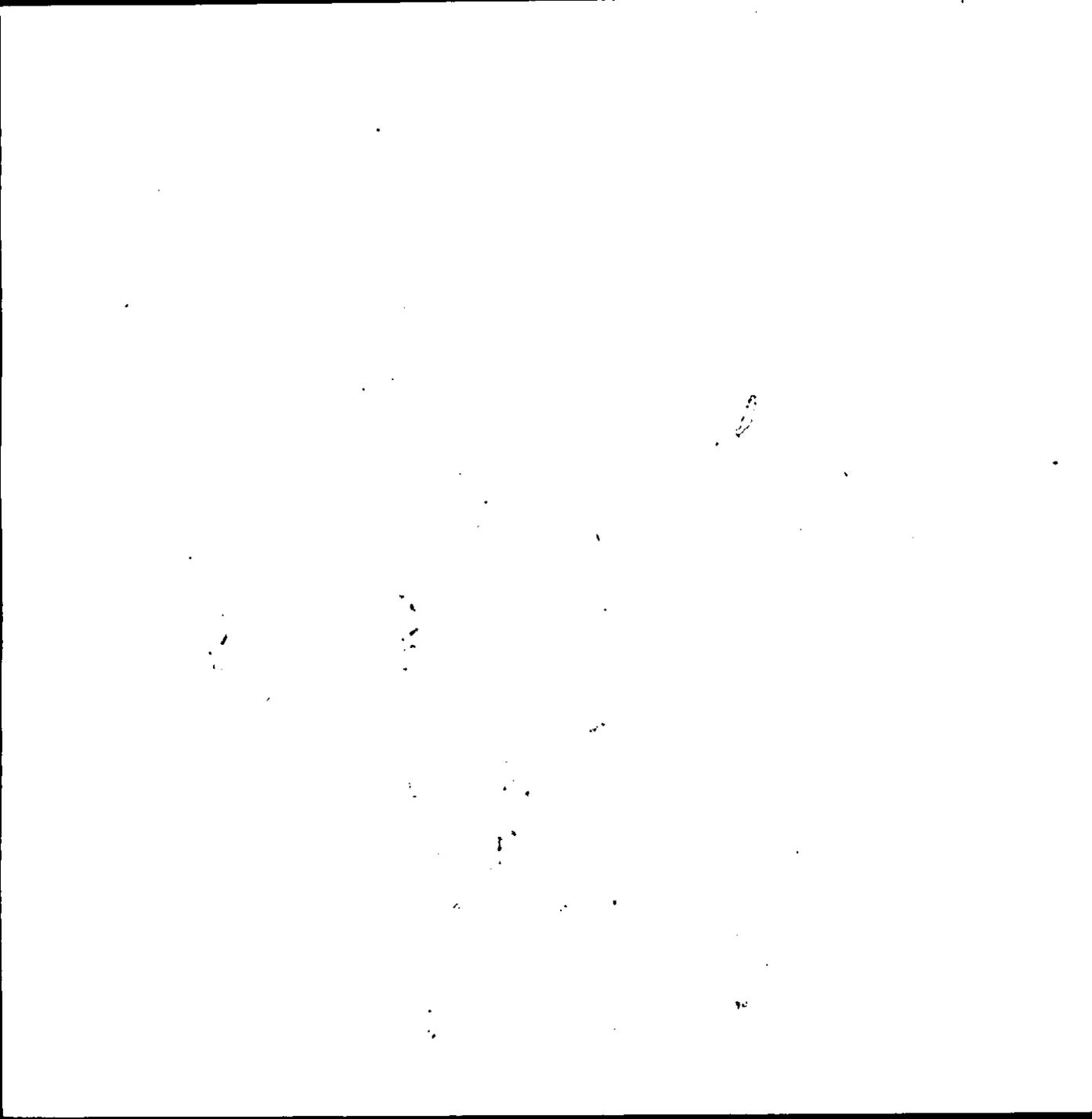
WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) J. S. Lewis, M. D.
 , 19 (Address) Parma

*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 Madison Mo. DATE OF BURIAL 7-27-1929

20. UNDERTAKER J. M. Hill ADDRESS Bellevue

PARENTS



**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 New Madrid Registration District No. 605 File No.
 Township Cond Primary Registration District No. 2804 Registered No.
 City (No. St. Ward)

2. FULL NAME

Sandra Maloney
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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 7/27/24 Miss C. S. Blackburn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 26 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:

General Septicemic
hæmorrhagic-acidotic
apnea to hand!
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) abscess on hand
 (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

1538

S-25325