

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

Do not use this space.

26734

**PLACE OF DEATH**

County Shelby

Registration District No. 830

Township Leitch

Primary Registration District No. 6070

City (No. \_\_\_\_\_) \_\_\_\_\_

File No. 27

Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Rachel McRae

(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. In MARRIED, WIDOWED, OR DIVORCED**

HUSBAND OF (OR) WIFE OF

Frank McRae

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

June 3 - 1851

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

78

1

**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)**

(STATE OR COUNTRY)

Ill.

**10. NAME OF FATHER**

Benjamin Jones

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

N.Y.

**12. MAIDEN NAME OF MOTHER**

Mary Jones

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

not known

**14.**

INFORMANT (Address)

R. F. McRae  
Shelburne, Mo.

**15.**

FILED

7-10-29 Madge Good  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

7-3-1929

**17.**

I HEREBY CERTIFY, That I attended deceased from 6-1-29, 1929, to 7-1-29, 1929 that I last saw her alive on 7-1-29, 1929, and that death occurred, on the date stated above, at 11 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Valvular Heart Disease

**CONTRIBUTORY (SECONDARY)**

900

**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? \_\_\_\_\_

no  
no  
Clinical.  
A. M. Wood, M. D.

(Signed) \_\_\_\_\_, M. D.  
7-5-29, (Address) Shelburne 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**

**DATE OF BURIAL**

900, F. Shelburne

July 5th 1929

**20. UNDERTAKER**

**ADDRESS**

G B Brothers

Shelburne Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUL 10 1929

235

2

31

