

28 1929 104

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

Do not use this space.

26752

1. PLACE OF DEATH

County Stone
Township Stone
City Crane (No.)

Registration District No. 842
Primary Registration District No. 4572

File No.
Registered No.
St. Ward

2. FULL NAME

Mary Emma Andrews

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

Length of residence in city or town where death occurred 8 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or min.
82 7 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ida
(STATE OR COUNTRY)

10. NAME OF FATHER John Andrews
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Liza McClutock
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)

14. INFORMANT Alma Richards
(Address) Springfield Mo

15. FILED 7-30-1929 Mrs. Ethel Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-6 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to July 6, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris
131
94A
102 (duration) yrs. mos. ds.
CONTRIBUTORY Hypertension, Nephritis
(SECONDARY) (duration) 2 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) W. P. Smith, M. D.

7-6, 1929 (Address) Crane 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 Springfield Mo DATE OF BURIAL 7-7 1929

20. UNDERTAKER Chisgw ADDRESS Springfield

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... ..

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**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 Stone
Township Crane
City Crane (No.)

Registration District No. 84-2
Primary Registration District No. 43-12

File No.
Registered No.
St. Ward

2. FULL NAME

Henry Samuel Andrews

(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 m 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) 1846-11-12

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
82 7 25

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1929
17. I HEREBY CERTIFY That I attended deceased from 1929, to 1929,
(that I last saw h. after on 1929, 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 29 (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 29

20. UNDERTAKER ADDRESS

15. FILED 7-30-29 Mrs Ethel Duggitt
REGISTRAR

SUPPLEMENTARY

101 RECEIVE A FEE FOR CERTIFICATES 1. TIL 1. AT CC LETE IS PRESCRIBED BY L. 7 Imp. REGIST. CAL

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