

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township St Joseph
City St Joseph (No. 1001)

Registration District No. 85
Priority Registration District No. 1001

File No. 27061
Registered No. 1023
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward Coffee Mo
(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 Mose

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
68 3 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. House work.
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Goddaway Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Benj Dewitt

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

12. MAIDEN NAME OF MOTHER Martha Boreff

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

14. INFORMANT A F Brown
(Address) Coffee Mo

15. FILED 9/31, 19 29
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 19 29, to Aug 31, 19 29 that I last saw her alive on Aug 31, 19 29, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma liver
4 1/2 (duration) yrs. mos. ds.
Unknown

CONTRIBUTORY (SECONDARY) None
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Unknown
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Physician's exam
(Signed) F. W. [Signature], M. D.
9/1, 19 29 (Address) Mercy Hospital

*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 Coffee Mo DATE OF BURIAL Sept 3 19 29

20. UNDERTAKER Heeman Funeral Home ADDRESS 1946 Colburn

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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