

24 1929

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

Do not use this space.

27184

1. PLACE OF DEATH

County Carroll
Township
City Carrollton (No. St. Ward)

Registration District No. 135
Primary Registration District No. 301D

File No.
Registered No. 195

2. FULL NAME

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

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

Hillard Atherton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-8-1884

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 | 9 | 9

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER L. B. Jenkins

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

12. MAIDEN NAME OF MOTHER Hattie Woods

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

14. INFORMANT Hillard Atherton
(Address) Wakenda Mo

15. FILED 8/19 19 29 W. E. Jamison
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-17 19 29

17. I HEREBY CERTIFY That I attended deceased from 8-15 19 29, to 8-17 19 29, and that I last saw her alive on 8-17 19 29, and that death occurred, on the date stated above, at Carrollton Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis
Intestinal Obstruction
54 B
12 B
127 (duration) yrs. mos. 2 wks.
CONTRIBUTORY Abroad Junior of
(SECONDARY) Uterus (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? No.

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? H. B. Jones

(Signed) H. B. Jones M. D.

8/19 19 29 (Address) Carrollton 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 Oak Hill Cem DATE OF BURIAL 8-19 19 29

20. UNDERTAKER Standley ADDRESS Carrollton

11. 5. 1940

Was this Fibroid
Tumor of uterus ma-
lignant?
(cancer?)

No it was not

S(2)-27184
1929

**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 Carroll

Registration District No. 135

File No. _____

Township _____

Primary Registration District No. 3010

Registered No. 88

City Carrollton (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 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) _____

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 _____ 19 _____ Mrs. E. E. Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 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 peritonitis

CONTRIBUTORY (SECONDARY) Fibroid tumor of the uterus (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

ABILEE-(2)S