

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

Do not use this space.

27212

1. PLACE OF DEATH

County Cass

Registration District No. 156

File No. _____

Township _____

Primary Registration District No. 4090

Registered No. 40

City Harrisonville (No. _____) St. _____ Ward _____

2. FULL NAME

MARY ANN SWITSER

(a) Residence No. 3529 WYANDOTTE St., 100 Ward. 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. 1/2 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 wife of) DAVID NEWTON SWITSER

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JULY 20 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 | 0 | 14

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) East House
(c) Name of employer

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

10. NAME OF FATHER Geo A. Converse

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

12. MAIDEN NAME OF MOTHER Mary Ann Haley

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

14. INFORMANT (Address) H. A. Switser
3529 Wyandotte, Mo

15. FILED 8/4 19 29 D. S. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) AUG 4 19 29

17. I HEREBY CERTIFY That I attended deceased from Aug 4 1929 to Aug 7 1929 that I last saw her alive on Aug 4 1929 and that death occurred, on the date stated above, at 19 29 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Fracture to base of knee from falling on concrete when stepped from auto while moving

CONTRIBUTORY (SECONDARY) 2 INJ (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) David S. Long, M. D.
8/4 19 29 Address Hville, 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 McKay Grove Cem Clayton Mo DATE OF BURIAL _____

20. UNDERTAKER W. H. Long ADDRESS _____

**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 Cass

Registration District No. 156

File No.

Township

Primary Registration District No. 7090

Registered No. 40

City Farmersville (No.) St. Ward)

2. FULL NAME

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1929

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... that I last saw h. all on 19..., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture to base of skull from falling on concrete when stepped from auto (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cass County (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

1880 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)..... M. D.

, 19... (Address) 216

*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

S-27212