

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

Do not use this space.

24 1929

27357

1. PLACE OF DEATH

County Carroll Registration District No. 354
 Township Union Primary Registration District No. 2358
 City Union St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1 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.

Margaret Ambrose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. M. Ambrose
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8 - 1838
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 4 22

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) Union Co. Mo
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER James McFally
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT Robert Ambrose
 (Address) Union

15. Filed Aug 2 1929 by J. H. Finkle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 2 1929
 17. I HEREBY CERTIFY That I attended deceased from Aug 1 1929 to Aug 2 1929
 that I last saw h. _____ alive on Aug 1 1929 and that death occurred, on the date stated above, at 12:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Venemic Poisoning

132 D
 134 B (duration) yrs. mos. ds.
 CONTRIBUTORY refractive (SECONDARY)
 (duration) yrs. mos. ds.

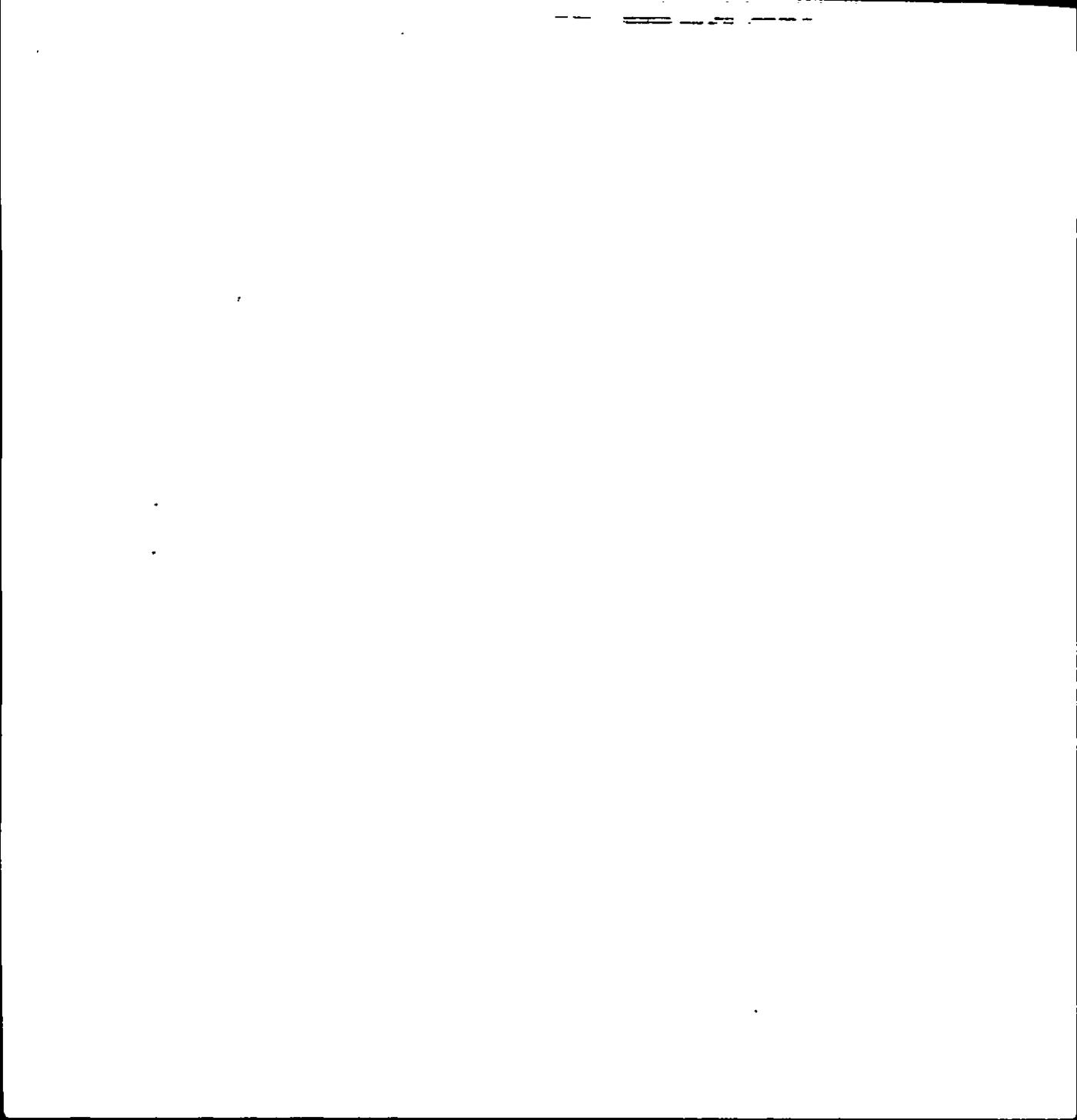
18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) Dr. J. H. Finkle, M. D.
Aug 2 1929 (Address) Union

*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 Union DATE OF BURIAL Aug 5 1929
Meadey. County

20. UNDERTAKER J. S. Jones ADDRESS Union



**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 Lavaca Registration District No. 25-4 File No. _____
 Township Marion Primary Registration District No. 3358 Registered No. 18
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Margaret Ambrose
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8 - 1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 4 24

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 Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not known

14. INFORMANT (Address) _____

15. FILED Aug 2, 1929 John Frank REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 2 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:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (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

S-27357