

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

Do not use this space.

29902

1. PLACE OF DEATH

County Wayne
Township St. Frances
City (No.)

Registration District No. 890
Primary Registration District No. 4500
6188

File No.
Registered No.
St. Ward

2. FULL NAME

Minnie H. Joiner

(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 44 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*) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16, 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 7 15

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)
(c) Name of employer self

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

10. NAME OF FATHER Flynn Hale

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo.

12. MAIDEN NAME OF MOTHER Sarah Talley

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

14. INFORMANT Lewis Hall
(Address) Greenwell, Mo

15. FILED 8/31 29 A. G. Langston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from July 29, 1929, to Aug 29, 1929, that I last saw her alive on Aug 14, 1929, and that death occurred, on the date stated above, at 10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis

CONTRIBUTORY (SECONDARY) (duration) 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?

(Signed) Geo F. Wagner, M. D.

8-31, 1929 (Address) Greenwell Mo

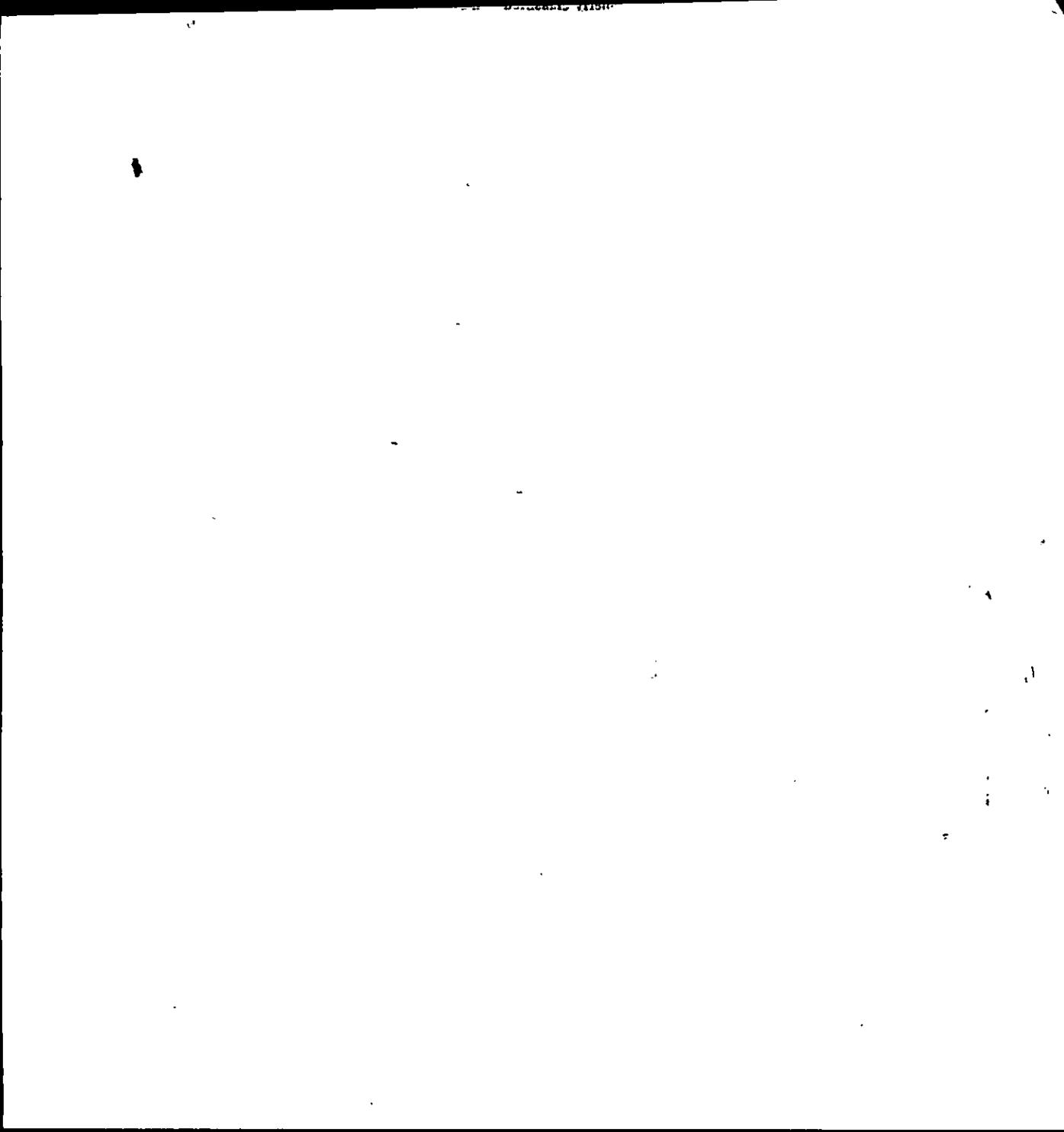
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Pleasant Valley - 9-1- 19 29

20. UNDERTAKER ADDRESS

✓



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wayne Registration District No. 890 File No. _____
 Township St. Francis Primary Registration District No. 6188 Registered No. _____
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Minnie H. Joiner

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1929

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

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.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Tuberculosis (Pulmonary)
 (duration) _____ yrs. _____ mos. _____ ds.

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.....

CONTRIBUTORY (SECONDARY)

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

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

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.

PARENTS
 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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 8/31 1929 A. E. Templeton REGISTRAR

20. UNDERTAKER ADDRESS
none

CAUSE OF DEATH in plain terms, so that it may be properly understood. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-29902