

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

Do not use this space.

30934

3958

1. PLACE OF DEATH

County Jackson
Township Kanawha
City W.C. Mo. (No. General Hosp #2)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1215 Franklin Rd. F. Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 25 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 Female
4. COLOR OR RACE Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
48

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Maids 54B 171B
(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) Johnson County Mo.

10. NAME OF FATHER Simon Brown

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

12. MAIDEN NAME OF MOTHER Rachael Young

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

14. INFORMANT (Address) Eliza Marshall 1407 Madison

15. Haystack, Mo. FILED 9/21, 1929 M. M. Crowe REGISTRAR
asal

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-1-29, 19____, to 9-18-29, 1929, that I last saw h. u. alive on 9-18-29, 1929 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Post Operative
Substernal Abscess
from fibroid Tumor
(duration) 24 yrs. — mos. — ds.

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

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

1 DID AN OPERATION PRECEDE DEATH. DATE OF 9-13-29

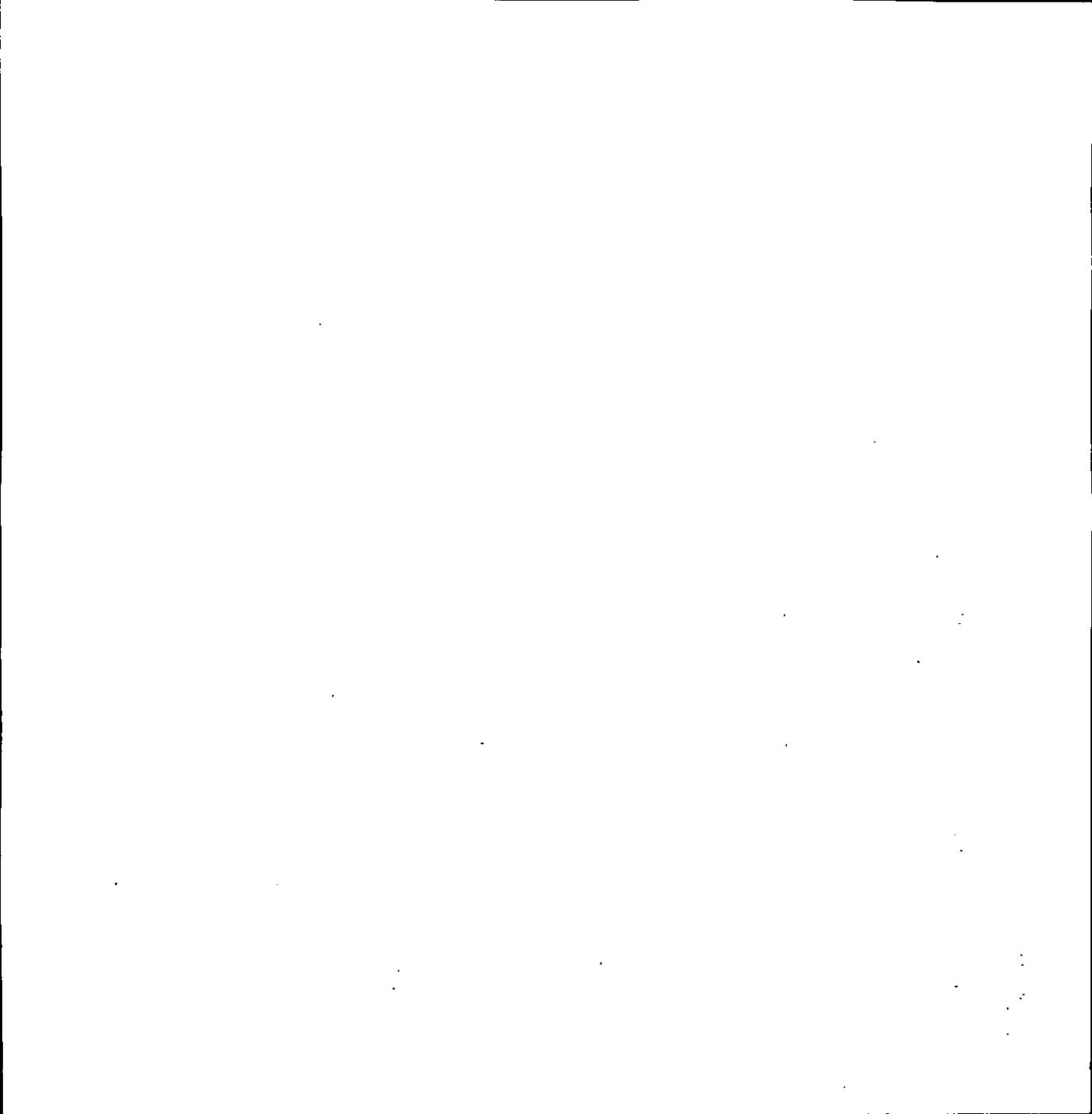
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) J. M. Smith, M. D.
9-19, 1929 (Address) R. Gen Hosp #2 W.C. 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 Haystack Cem. DATE OF BURIAL 9/23 1929

20. UNDERTAKER Atkins Bros ADDRESS 1714 Lydia



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 399

File No.....

Township.....

Primary Registration District No. 1012

Registered No. 3958

City X City (No.....)

St. Ward)

2. FULL NAME

Mary Henry

(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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid (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 9/21 19 29 M. M. Loure REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 19 29

17. I HEREBY CERTIFY That I attended deceased from..... 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:

Post-operative intestinal obstruction
due to fibroid tumor
non-malignant

CONTRIBUTORY (SECONDARY) (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

REGIS. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30934