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

Do not use this space.
33771
4223

1. PLACE OF DEATH

County: Jackson Registration District No.: File No.:

Township: Kan Primary Registration District No.: Registered No.:

City: K. C. Mo. (No. St. Joseph Hospital St. Ward)

2. FULL NAME Mrs. J. M. Rider

(a) Residence. No. Henrietta, Mo. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Fe	White	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May - 8, 1876

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
53	5	24	

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

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

PARENTS
10. NAME OF FATHER Freeman Haskell
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Martha Ann Stigall
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ray Co.
(STATE OR COUNTRY) Mo.

14. INFORMANT Jas. Rider
(Address) Henrietta, Mo.

15. FILED 10/12, 1929 M. M. Crowe REGISTRAR
ossl

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 12 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-1-28, 19..., to 10-12, 1929 that I last saw her alive on 10-11, 1929 and that death occurred, on the date stated above, at 3 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Colon (ascending)
460 (duration) yrs. 18 mos. ds.

CONTRIBUTORY (SECONDARY) 475 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 10-1-28
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Eugene P. Hamilton, M. D.
10-12 1929 (Address) 602 Argyle

*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
Forest Cemetery Lexington, Mo.	Oct 12, 1929
20. UNDERTAKER	**ADDRESS**
Mrs. E. L. Foster	K. C. Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.