

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

Do not use this space.
**34016
4469**

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Staw Primary Registration District No. _____
 City Hausse City No. 809 Cypress St. _____ Ward _____

2. FULL NAME Margaret Mandelaine Pasley
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) Roscoe, Mo.
 (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 2 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** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18, 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>	<u>1</u>	<u>11</u>	

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) Parkersburg
 (STATE OR COUNTRY) Va.

10. NAME OF FATHER W. H. Hartline

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

12. MAIDEN NAME OF MOTHER Miss Canada

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

14. INFORMANT A. M. Pasley
 (Address) 809 Cypress

15. FILED 10-29-29 Mc M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1929

17. I HEREBY CERTIFY, That I attended deceased from about May 15th 1929, to Oct 29 1929, that I last saw her alive on Oct 26th 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Intercistial Nephritis
History 1 yr.
from knowledge (duration) yrs. 6 mos. ds.
CONTRIBUTORY (SECONDARY) Progressive Anemia
 (duration) 1 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? usual tests
 (Signed) C. J. Davis M.D. M.D.
Oct 29, 1929 (Address) 406 State Ave
KE. Kans.

*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 Roscoe, Mo. **DATE OF BURIAL** Oct 30 1929

20. UNDERTAKER L. H. Newcomer's **ADDRESS** South

MARGIN RESERVED FOR BINDING
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.

Mr H G Davis
Hoboken N.J.
Pa. 3277.