

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

Do not use this space.

34738

1. PLACE OF DEATH

County Pueblito
Township Union
City Union (No.)

Registration District No. 711
Primary Registration District No. 5940

File No.
Registered No. 20
St. Ward)

2. FULL NAME

Nettie Case

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 7 7

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)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER Nathan M. Pagan

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Dorey George
(Address) Six and Mo

15. FILED 11/5, 19 29 A S Lick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 31, 1929 that I last saw h. alive on Oct 21, 1929, and that death occurred, on the date stated above, at 11 - 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Flu + Bronchial
Pneumonia both lungs
11A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 107A (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) J. P. ... M. D.
, 19 (Address) Union 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 Pueblito, Mo DATE OF BURIAL 11-4-29

20. UNDERTAKER Fred N Gilberts ADDRESS Six and Mo

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.

UN-ADJUDICATED PERMANENT RECORD

**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 Pulaski

Registration District No. 711

File No.

Township Union

Primary Registration District No. 3940

Registered No. 20

City

(No.)

St. Ward)

2. FULL NAME

Nette Case

(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

F

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)

March 24, 1858

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.

71

7

7

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)

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).....

15.

FILED 11-5, 19 29

A. S. Dick

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 31, 19 29

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

that I last saw him....., 19....., and that
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

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

19.....

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH INK, IN THIS SUPPLEMENTARY RECORD

N. B.—Every item of information 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.

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

1929
34738