

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

Do not use this space.

Dr Roy

36526

File No. _____
Registered No. 17
St. _____ Ward _____

1. PLACE OF DEATH
County Shelby Registration District No. 827
Township Clear Primary Registration District No. 4500
City Clarence (No. _____)

2. FULL NAME Mrs Kate Rank
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 26 - 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
69 6 17

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) Morgan Co
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Thos Jennings

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

12. MAIDEN NAME OF MOTHER Mary Blair

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

14. INFORMANT Mrs Fannie Jennings
(Address) Clarence Mo

15. FILED 10/4 1929 Roy Hamilton
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arthritis Deformans

57A (duration) yrs. mos. ds.
56B Rheumatism
CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.
57A

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Frank K. Roy, M. D.

10/13, 1929, (Address) Clarence 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
St Leon Macon Co Mo Oct 15 1929

20. UNDERTAKER ADDRESS
Albert Skinner Macon

WRITE PAINLY, 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.

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