24
SC 19 1929

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

Do not use this space.

36652

1. PLACE OF DEATH
County Clay
Township Fishing River
City ..... (No. ..... St. ..... Ward)

Registration District No. 198
Primary Registration District No. 5277 a

File No. .....
Registered No. 126

2. FULL NAME Paulina Cooper

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
female	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 13-1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	7	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home 131 95B 106
(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) missouri

PARENTS
10. NAME OF FATHER Silas Holmes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Nancy Bailey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky.

14. INFORMANT Mrs Virgil Hunt
(Address) Excelsior Spgs Mo

15. FILED 11/6 1929 Y.D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 6, 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929 to Nov 6, 1929 that I last saw her alive on Nov 5, 1929, and that death occurred, on the date stated above, at 8 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilation of heart
Had Systolic B.P. 280 for years
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial nephritis (duration) several 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) John F. Grace, M. D.
Nov 7, 1929 (Address) Excelsior Springs 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 Brown Hill
DATE OF BURIAL Nov, 8 1929

20. UNDERTAKER Herbert Hope
ADDRESS Excelsior Springs Mo

WRITE PLAINLY, WITH UNFADING INK

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.