

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

39690

1. PLACE OF DEATH

County Boone

Registration District No. 73

File No. 291

Township Columbia

Primary Registration District No. 3112

Registered No. _____

City _____

(No. _____)

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. Boone Co.

St. _____

Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

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

Dec. 22

7. AGE

YEARS

MONTHS

DAYS

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

75

11

- 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Home wife

(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)

St Joe Mo.

10. NAME OF FATHER

Christopher Todd

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Joe Mo.

12. MAIDEN NAME OF MOTHER

Elmer Stephens

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Boone Co Mo.

14.

INFORMANT

(Address)

Ederest Adair

Stephens Mo.

15.

FILED

12-22-19 Beatrice Griggs

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 22 19 29

17.

I HEREBY CERTIFY, That I attended deceased from last not attended her, 19____, to _____, 19____, that I last saw her alive on Dec. 21, 19____, and that death occurred, on the date stated above, at 4:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

I only saw her after death
Her history indicates she died
from senile debility superinduced
by Mal Nephritis (duration) _____ yrs. mos. 21 ds.

CONTRIBUTORY (SECONDARY)

Mal Nephritis (duration) 1 yrs. 2 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

R. L. Hopper

M. D.

, 19

(Address) Stephens 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Stephens Cemetery Boone

Dec 23 19 29

20. UNDERTAKER

ADDRESS

B F Baker

Columbia

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

1. PLACE OF DEATH

County..... File No.....
 Township..... Registered No.....
 City..... (No.)..... St. Word.....

2. FULL NAME

(a) Residence, No..... Word.....
 (Usual place of abode)
 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).....

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

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

7. AGE YEARS MONTHS DAYS IF LESS THAN 1
 day, hrs. min.

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).....

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).....

PARENTS

14.

INFORMANT
 (Address).....

15.

FILED....., 19..... REGIST

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
 (SECONDARY)

..... (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)....., 19..... (Address)..... M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

DATE OF REMOVAL.....

DATE OF BURIAL.....

ADDRESS.....

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Boone
Township Columbia
City (No.)

Registration District No. 43
Primary Registration District No. 5712

File No.
Registered No. 291
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward
(Usual place of abode)

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.

Molly Adair

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) Jan 9 1854
7. AGE YEARS MONTHS DAYS 75 11 3
If LESS than 1 day, hrs. or min.

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)

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 1-24 1930 Beatrice Grubb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 22 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

N. B.—Every item of information should be carefully supplied, and should be stated exactly. If 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

SUPPLEMENTARY

5-39690