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

Do not use this space.

32

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Atchison — Registration District No.: 19

Township: Clay — Primary Registration District No.: 4013

City: Rock Port Mo (No. ..... St. ..... Ward)

2. FULL NAME Mrs. L. M. Breeden

(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	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: L. M. Breeden

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 11-2-1860

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	2	29	

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): Penn.

PARENTS

10. NAME OF FATHER: Jacob Fenstemaker

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

12. MAIDEN NAME OF MOTHER: Stetler

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

14. INFORMANT: L. M. Breeden
(Address): Rock Port Mo.

15. FILED: 2-4-1930 Mary G. Chamberlain, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-31 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st 1930 for 3 or 4 years, 19..., to Jan 31st 1930, 19..., that I last saw her alive on Jan 30th, 1930, and that death occurred, on the date stated above, at 4:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
a General breakdown of central nervous system 5781
3 or 4 years (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) William R. Strickland, M. D.

130 -, 193 1 (Address) Rock Port, 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
Green Hill Cem.	2-2 1930
UNDERTAKER	**ADDRESS**
Katz Barnhisonew	Rock Port 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.