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

Do not use this space.

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1. PLACE OF DEATH
County Callaway — Registration District No. 102 — File No.
Township Jackson — Primary Registration District No. 4062 — Registered No. 259
City Aux Vasse (No. ..... St. ..... Ward)

2. FULL NAME Rosa Lee Jones
(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: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16 1875

7. AGE: Years 55 — Months 8 — Days 12 — If LESS than 1 day, ... hrs. or ..... min.

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) Aux Vasse, Mo.
(STATE OR COUNTRY) Callaway Co.

PARENTS
10. NAME OF FATHER Sam Woolery
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Calloway Co. Mo.
12. MAIDEN NAME OF MOTHER Mary Woolery
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

14. INFORMANT Sam Woolery
(Address) Aux Vasse, Mo.

15. FILED 1/29 1930 H. G. Thomas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/28 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1929 to Jan 28, 1930 that I last saw her alive on Jan 28, 1930 and that death occurred, on the date stated above, at 10 00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Carcinoma
(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (SECONDARY) Anorexia
(duration) ..... yrs. 2 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 14/29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Exam of specimen at time of operation
(Signed) H R Hiss, M.D.
, 19 (Address) Aux Vasse 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: Plesant Hill — DATE OF BURIAL: Jan 30 1930

20. UNDERTAKER: Glen Y. Maupin — ADDRESS: Aux Vasse Mo.

N. B.—[illegible] information should be carefully supplied. AGE should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa[illegible]

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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 Callaway — Registration District No. 102 — File No.
Township — Primary Registration District No. 4062 — Registered No. 259
City Aux Vasse (No. ..... St. ..... Ward)

2. FULL NAME Rosa Lee Jones

(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: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16-1873

7. AGE: 34 YEARS — MONTHS: 8 — DAYS: 12 — 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)

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 1/29 1930 H. G. Thomas
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1930

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Carcinoma
Left Breast, primary seat.

..... (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

SUPPLEMENTARY

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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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THE COMPLETE

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