

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

Do not use this space.

1032

1. PLACE OF DEATH

County Jackson
Township Law
City James City (No. 2621)

Registration District No. 399
Primary Registration District No. 102

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

2. FULL NAME

Mrs. Joseph Pringle
(a) Residence. No. 2621 St. 14 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 50 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18 - 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 _____ 13

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) Cincinnati, Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER Not known

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

12. MAIDEN NAME OF MOTHER Lintner

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

14. INFORMANT Mrs. Carl Lammert
(Address) 7913 East 28 St

15. Jan 2, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Jan 1, 1930. that I last saw her alive on Jan 1, 1930, and that death occurred, on the date stated above, at 7:30 a.m. 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Purulent parotitis
1878
68
1158 (duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY Addison's Disease (Nephritis) (SECONDARY)
renal disease (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) G.H. Hone M. D.

Jan 2, 1930 (Address) 1000 Rialto Bldg

*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 Forest Hill Cemetery DATE OF BURIAL Jan. 3 1930

20. UNDERTAKER Melody Melville ADDRESS 3123 Euclid Ave. James City, 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.

WITH UNFADING INK—

2535
2
10

1950

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

IN SENATE

January 10, 1950

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1949

ALBANY: J.B. LIPPINCOTT COMPANY, 1950

THE STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY

1950

Is Parotitis here
used in the
sense of mumps
or not?

Purulent parotitis
practically never occurs
in mumps.

5(2)-1032

1930

**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..... Registration District No. 399 File No.....
Township..... Primary Registration District No. 1002 Registered No. 17
City H. City (No.....) St..... Ward.....

2. FULL NAME

Ms Joseph Pringle
(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) wid
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. 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 Jan 7, 1930 M. M. Brower REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 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:
Overlight Parotitis
not mumps - but secondary
to the weakness caused by the nephritis
..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 12910
..... (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.....

WRITE PLAINLY, 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S(e)-1032