

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

Do not use this space.

✓  
# 1658  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County Johnson Registration District No. 112  
Township Washington Precinct Registration District No. 5885  
City \_\_\_\_\_ (No. \_\_\_\_\_)

**2. FULL NAME** Mary Jane Hall

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 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) Jan-1-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 | | 5

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housekeeper  
(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) Cooper Co. Mo

10. NAME OF FATHER Wiley Maddox

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Barnett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) X

14. INFORMANT (Address) Ben Hall  
Trust Woster Mo

15. FILED 1/6 1930 J.A. Koch REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 - 1930  
17.

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Jan 5, 1930 that I last saw her alive on Jan 5, 1930, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

① Bronchial Pneumonia  
92A  
107A (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) ① Valvular Disease (duration) yrs. mos. da.

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

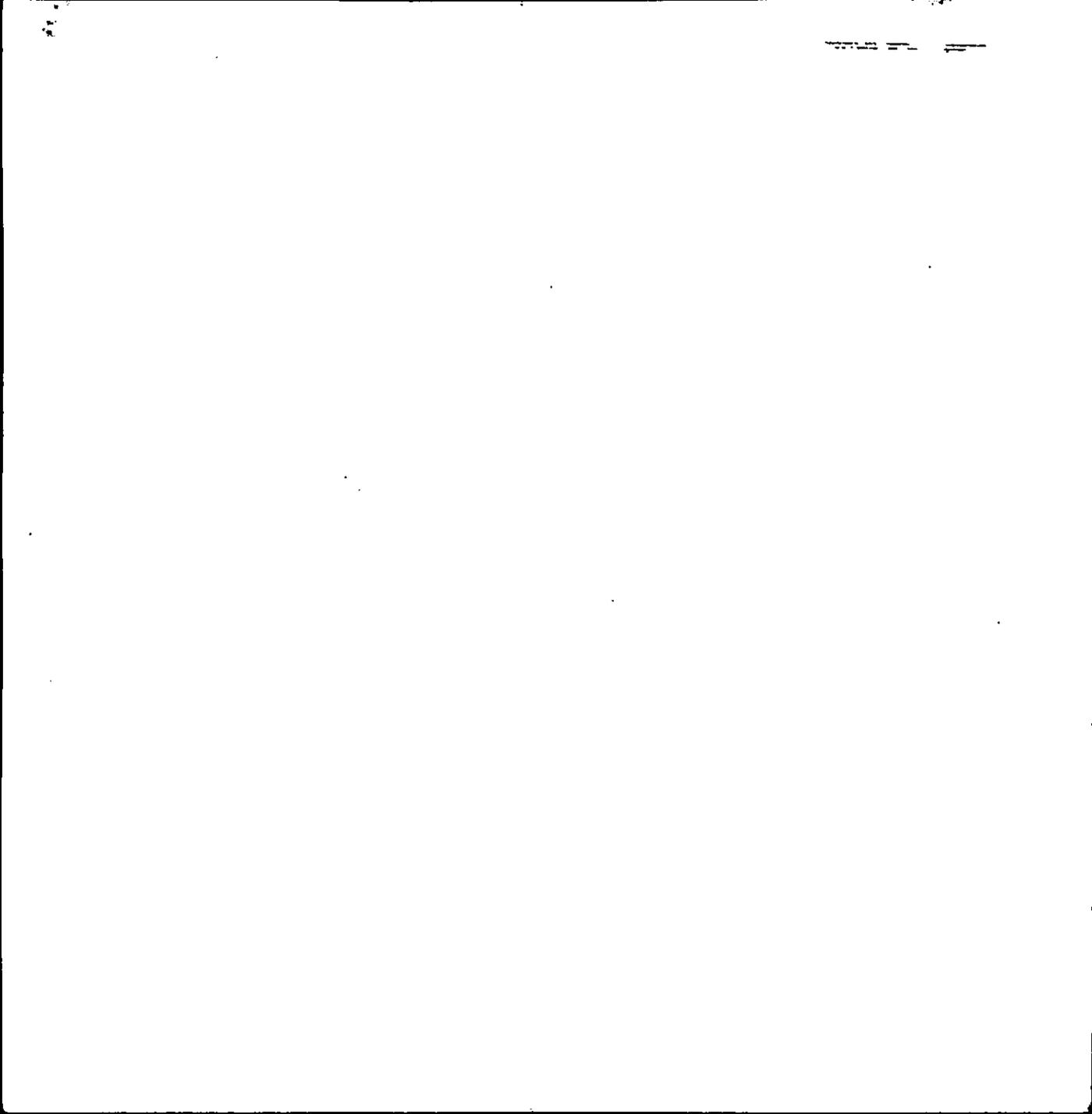
19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Plumeral  
(Signed) Paul Moore, M. D.  
, 19 (Address) Trust Woster Mo

\*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 Payne Cem. DATE OF BURIAL Jan 6 - 1930

20. UNDERTAKER E.L. Sauls ADDRESS K.N. Mo

PARENTS



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Johnson Registration District No. 112 File No. 4  
 Township Knover Primary Registration District No. 33-85- Registered No. 2  
 City..... (No..... St..... Ward.....)

2. FULL NAME Mary Jane Hall  
 (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) Jan-1-1856  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
74 - 4

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work housekeeper  
 (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) Comper Co. Mo.

10. NAME OF FATHER Wiley Maddox

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

12. MAIDEN NAME OF MOTHER Barnett

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

14. INFORMANT Ben Hall  
 (Address) Knob Noster mo.

15. FILED Mar 12 1930 Thermon S. Taylor REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1930  
 17. I HEREBY CERTIFY that I attended deceased from July 1 1898 to Jan 5 1930 that I last saw her alive on Jan 5 1930 and that death occurred, on the date stated above, at 12 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Bronchial Pneumonia  
 (duration) .....yrs. ....mos. 17 ds.  
 CONTRIBUTOR (SECONDARY) Valvular Disease  
 (duration) .....yrs. ....mos. ....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? Clinical

(Signed) G.W. Grove, M. D.

, 19 (Address) Knob Noster 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 Payne Cem. DATE OF BURIAL Jan 6 1930

20. UNDERTAKER C. L. Smith ADDRESS K. Noster mo.

A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REGI

SUPPLEMENTARY

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