

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

Do not use this space.

5622

1. PLACE OF DEATH

County Livingston
Township _____
City Chillicothe (No. _____)

Registration District No. 508
Primary Registration District No. 3026

File No. _____
Registered No. 145 Ward _____

2. FULL NAME

Mrs. Margaret Doublson

(a) Residence. No. Living - St. 3 - 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 24 - 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>69</u>	<u>-</u>	<u>11</u>	<u>-</u>	<u>4</u>

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) Ohio

PARENTS

10. NAME OF FATHER Adams Rook

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Albert Doublson
(Address) Chillicothe, Mo.

15. FILED 2/28/30 Reuben Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Feb. 28, 1930 that I last saw her alive on Feb. 25, 1930, and that death occurred, on the date stated above, at 8:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Insufficiency (mitral regurgitation)
92 A
95 B (duration) several yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

POW (duration) 9 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? symptoms
(Signed) Amgrace M. D.

Feb. 28, 1930 (Address) Chillicothe 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 New town Mo. DATE OF BURIAL Mar. 1 - 1930

20. UNDERTAKER James D. Gordon ADDRESS Chillicothe 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

