

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.

MAR 28 1930

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

Do not use this space.

5881

1. PLACE OF DEATH

County *Ozark*
Township *Gasper*
City (No.)

Registration District No. *920*
Primary Registration District No. *5859*

File No.
Registered No. *3*
St. Ward)

2. FULL NAME

(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 *35* 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) *widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *P. J. Green*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 8 1847*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
83 1 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House work*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Shannon*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Peter Renfro*

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

12. MAIDEN NAME OF MOTHER *Syntha Quirk*

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

14. INFORMANT *Lula Friend*
(Address) *Isabella*

15. FILED 19 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 19 1930*

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
that I last saw him alive on 19....., and that death occurred, on the date stated above, at 19..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

52

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 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

Isabella Cemetery *Feb 19 1930*

20. UNDERTAKER ADDRESS

John Blair Isabella

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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 Ozark
Township Gusper
City (Pollyann) (No. 5859)

Registration District No. 920
Primary Registration District No. 5859

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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.

Feb 19, 1930 Mary F. Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/19 1930

17. I HEREBY CERTIFY That I attended deceased from _____
_____ 19____ to _____ 19____
that I last saw him _____ after on _____ 19____, and that
death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

NO ADDITIONAL
Dropsy
(duration) _____ yrs. 2 mos. ds.
CONTRIBUTORY (SECONDARY) Cancer of nose
(duration) 11 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) Lula Friend M.D.

2/19, 1930 (Address) Isabella m

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

Isabella Cemetery Feb 19 1930
20. UNDERTAKER ADDRESS

John Blair Isabella m

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1885-5