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.

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

1 PLACE OF DEATH

County Carroll

Township ~~Ridge~~ or Village Bosworth or City ..... (NO. ..... St.; ..... Ward)

Registration District No. 134 File No. .....

Primary Registration District No. 4075 Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs Renna M. Stafford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

6 DATE OF BIRTH November (Month) 10 (Day), 1874 (Year)

7 AGE 55 yrs. 4 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS

10 NAME OF FATHER James Booker

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind

12 MAIDEN NAME OF MOTHER Rebecca Williams

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elias Stafford
(Address) Bosworth Mo

15
Filed Mar 30 1930 Mrs. Boss Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 March (Month) 27 (Day), 1930 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1, 1930, to Mar 27, 1930 that I last saw her alive on Jan 25, 1930 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
Robular Pneumonia
90 A 92 A 1 [illegible]
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation
8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R M Bussan M. D.
3-28, 1930 (Address) Carrollton Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Big Creek Cemetery DATE OF BURIAL 3/29, 1930

20 UNDERTAKER Louis Leipard ADDRESS Bosworth Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS