MAR 28 1930

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

Do not use this space.

9461

1. PLACE OF DEATH

County Macon — Registration District No. 5-35 — File No. 1

Township Narrows — Primary Registration District No. 5-72d — Registered No. 117

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Cynthia Ellen Staats

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

(b) 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): M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Geo Staats

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 28 - 1914

7. AGE: Years 15 — Months 5 — Days 3 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN): Columbia
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Walter Hughes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Bessie Hawkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo

14. INFORMANT: Geo Staats
(Address): Excello Mo

15. Filed Mar 10 1930 J. J. King, Registrar

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19 86 that I last saw her alive on Mch 1, 19..., and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Secondary Anemia
1392
7113
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY): Hemorrhage Uterus
(duration) yrs. 2 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) A M Reeves, M. D
3/1, 1930 (Address) Macon 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: Nashville Cem — DATE OF BURIAL: Mar 2 1930

20. UNDERTAKER: Albert Skinner — ADDRESS: Macon 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.

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: Macon — Registration District No.: 535 — File No.:
Township: Macon — Primary Registration District No.: 5-720 — Registered No.: 117
City: (No. St. Ward)

2. FULL NAME: Cynthia Ellen Staats

(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.

PHYSICIANS should state statement of OCCUPATION is very important.

Y ARE COMPLETE AS PRESCRIBED BY LAW

stated EXACTLY.

N. B.—Every item of infor CAUSE OF DEATH is pla

REGISTRARS SHALL NO

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F.	W	M

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

Was this a puerperal case?

The history given me was not had 2 months bron Hemorrhagic
A M Ramsey

PARE

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT
(Address)

15. April 9, 1930 J. J. King
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 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:
Secondary Anemia
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Hemorrhage of Uterus
(duration) yrs. mos. ds.

SECONDARY

140

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

S-9461