

APR 30 1930

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

Do not use this space.

9991

1. PLACE OF DEATH
 County St. Francois Registration District No. 773
 Township Farmington Primary Registration District No. 4464
 City Farmington (No. _____) St. _____ (Ward) _____

2. FULL NAME Isabelle C. Curthier
 (a) Residence. No. Crystal Lake 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 Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 11 1

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

9. BIRTHPLACE (CITY OR TOWN) New Jersey
(STATE OR COUNTRY)

10. NAME OF FATHER Wm E Bushnell

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

12. MAIDEN NAME OF MOTHER Mrs M C Plannel

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

14. INFORMANT W E Curthier
(Address) Crystal Lake Mo

15. FILED 3/25/30 BY Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 25 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, about 12:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93C
 (duration) 10 yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 90B
 (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 _____
 (Signed) R. O. Deater M. D.
Feb. 25 1930 (Address) DeLoze 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 St Louis Mo DATE OF BURIAL Mar 27 1930

20. UNDERTAKER Deater & Vineyard ADDRESS St Louis Mo

Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. Cause of DEATH in plain terms, so that it may be properly classified.

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