

APR 30 1930

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

Do not use this space.

11351

1. PLACE OF DEATH

County Shelby  
Township Jackson  
City..... (No.....).....

Registration District No. 828  
Primary Registration District No. 6090

File No.....  
Registered No.....  
St..... Ward.....

2. FULL NAME Mary Ellen Slide

(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. 6 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4-1930

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

17. I HEREBY CERTIFY, That I attended deceased from 2-1-1930 to Mar 4 1930 that I last saw h... alive on 3-4-1930, and that death occurred, on the date stated above, at 4 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Broncho-Pneumonia  
119 B  
107 A

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
6 7

(duration) yrs. mos. 24 ds.

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

CONTRIBUTORY (SECONDARY) Enterocolitis  
(duration) yrs. mos. 12 ds.

9. BIRTHPLACE (CITY OR TOWN) Shelby Co. Missouri  
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH 113 B

10. NAME OF FATHER Thomas R. Slide

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

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

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Annie Rasmussen

WHAT TEST CONFIRMED DIAGNOSIS? Cultures  
(Signed) G. M. Wood, M. D.

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

3-4 1930 (Address) Shelbina Mo

14. INFORMANT James R. Slide  
(Address) Camden 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.

15. FILED 2/5 1930 Dr. C. T. White REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
V. P. O. R. Cemetery 3/5 1930

20. UNDERTAKER ADDRESS  
George Egan Shelbina Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

10 2

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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 Shelby Registration District No. 828 File No. ....  
 Township Jackson Primary Registration District No. 6040 Registered No. ....  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

Mary Ellen Shride  
 (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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24<sup>th</sup> 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
6 7

**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. FILED 3/5/30 Dr. A. T. White REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4 19 30

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:

.....  
 (duration)..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (SECONDARY) .....  
 (duration)..... 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)....., 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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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