

APR 30 1930

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

Do not use this space.

11516

1. PLACE OF DEATH
County Webster Registration District No. 898
Township E. Pallis Primary Registration District No. 6204
City Fardland (No. _____) St. _____ Ward _____

2. FULL NAME Katherine Rose Clouse
(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 1 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 19 - 1924

7. AGE 2 YEARS MONTHS 22 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) Webster Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Parby Clouse

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

12. MAIDEN NAME OF MOTHER Alma Burk

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

14. INFORMANT Parby Clouse
(Address) Fardland

15. FILED 3-13 1930 John W. Good
REGISTRAR m.c.

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 12 1930

17. I HEREBY CERTIFY, That I attended deceased on March 12, 1930, to _____, 19____, that I last saw her alive on March 12, 1930, and that death occurred, on the date stated above, at 4:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
enteritis
120B
129B / 114B
(duration) _____ yrs. _____ mos. 8 ds.

CONTRIBUTORY Intestinal hemorrhage
(SECONDARY)
(duration) _____ yrs. _____ mos. 2 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? Blood in stools
(Signed) A. E. Todd D.O. M.D.
, 19____ (Address) Marshfield 716

*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 MT Olive DATE OF BURIAL 8-13 1930

20. UNDERTAKER E. F. Starr ADDRESS Fardland Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

