

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

Do not use this space.

16256

1. PLACE OF DEATH

County Pickens Registration District No. 399 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 2214
 City _____ (No. _____) (General Hospital _____) (Ward _____)

2. FULL NAME

Margaret Doler, "Margaret Doler"
 (a) Residence, No. 675 Locust 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 Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
49
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Domestic
 (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 Henry Merritt
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky
 12. MAIDEN NAME OF MOTHER Maggie Merritt
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT Record Clerk
 (Address) General Hospital
 15. FILED 5/21, 1930 M. M. Crowe
 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-15 1930
 17. 12 HEREBY CERTIFY, That I attended deceased from 5-18 1930 to 5-18 1930 that I last saw her alive on 5-18 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Lobar Pneumonia
108
69E 10/10 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Toxemia
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH Unknown
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) H. M. S. M. D.
 19. 1930 (Address) General Hospital #2

*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 Highland DATE OF BURIAL 5-22-30
 20. UNDERTAKER H. W. Moor ADDRESS 1820 E 19th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

