Lewellen

Do not use this space.

16470

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

JUL 23 1930

1. PLACE OF DEATH
County Jasper
Township
City Joplin (No. , St. Ward)

Registration District No. 411
Primary Registration District No. no 2

File No.
Registered No.

2. FULL NAME Myrtle Ellen Bray
(a) Residence. No. ~~837 Washington~~ St. Ward. Baxter Springs Kansas
(Usual place of abode) St Johns Hospital (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 30 minutes How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 30. 1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	35	9	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home 54A 144B
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping 146
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mt Vernon
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Wm Holden.
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown.
12. MAIDEN NAME OF MOTHER Nathan Corwan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown.

14. INFORMANT Noel Irvon Bray
(Address) Baxter Springs Ks

15. FILED 5-27, 1930 A. Benson Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 26 1930

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1930 to May 26, 1930 that I last saw her alive on May 26, 1930, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrage / Internal from bursted tumor / Fibroid of Ovary
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Pregnant - 7 mo. with Uremia
(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) Chester E. Lewellen, M. D.
5/27, 1930 (Address) Baxter Springs

*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
Lowell Ks	5/28 1930
20. UNDERTAKER	ADDRESS
Harvey	Baxter Spgs

WRITE ... Y, WITH UNFADING INK---THIS IS A ... MANENT 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.

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: Jasper — Registration District No. 411 — File No.

Township — Primary Registration District No. 2002 — Registered No.

City: Joplin (No. ..., St. ..., Ward)

2. FULL NAME Myrtle Ellen Bray

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

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	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

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

7. AGE	YEARS	MONTHS	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)
(STATE OR COUNTRY)

PARENTS

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 8/21 19 30 — Mrs Quon Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 26 19 30

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw b... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage (Internal)
from Ruptured Tumor
of Fibroid of Ovary
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Ds Malignancy.
(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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

137

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

S-16470