

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

Do not use this space.

16926

1. PLACE OF DEATH

County Peru Registration District No. 651
Township Gible Prairie Primary Registration District No. 3862
City Peru (No. 1) St. _____ Ward _____

File No. _____
Registered No. 5-7
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/17/1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>46</u>	<u>0</u>	<u>29</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. H W
(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 A J Fletcher

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

12. MAIDEN NAME OF MOTHER D K

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

14. INFORMANT Trayman Moore (Address) Golda Ark.

15. FILED May 16 1930 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/16 1930

17. I HEREBY CERTIFY, That I attended deceased from May 2 1930 to May 16 1930 that I last saw her alive on May 15 1930, and that death occurred, on the date stated above, at 2-15 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

(duration) yrs. mos. 14 da.

CONTRIBUTORY (SECONDARY) 10 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. R. P. Moore M. D.
May 16, 1930 (Address) Canthersville, 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 Moored cemetery DATE OF BURIAL 5/16 1930

20. UNDERTAKER Friends ADDRESS Canthersville Mo

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.

WHITE LABEL, WITH EXPANDING INK—THIS IS A PERMANENT RECORD

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