

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

Do not use this space.

18372

1. PLACE OF DEATH

County..... Texas Registration District No. 868
Township..... Sherrill Primary Registration District No. 6149
City..... (No.) St. Ward.....

File No.
Registered No. 6

2. FULL NAME

Mauri Elizabeth Fagan
(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 <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas Fagan</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 1, 1844</u>		
7. AGE	YEARS <u>86</u>	MONTHS <u>18</u>
	DAY <u>18</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... <u>Retired Housewife</u> (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) Mo.

PARENTS	10. NAME OF FATHER <u>Simon West</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Doult/Knowl</u>
	12. MAIDEN NAME OF MOTHER <u>Standards</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Doult/Knowl</u>

14. INFORMANT..... Jno. Fagan
(Address) Licking Mo

15. FILED 5/19, 1932 W. R. Reid
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930 to May 19, 1930 that I last saw him alive on May 13, 1930, and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial Nephritis

131 (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129a (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)..... H. L. Reed..... M. D.
5/19, 1930 (Address) Licking

*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 <u>Hillside Cemetery</u>	DATE OF BURIAL <u>May 20, 1930</u>
20. UNDERTAKER <u>Marr & Thomas Licking Mo</u>	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.

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