

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

Do not use this space.

23125

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 3119
 Township Ross Primary Registration District No. 100 Registered No. 3119
 City Kennett (No. Kennett City Union) St. Mo. Ward

2. FULL NAME

Milar Julia
 (a) Residence, No. 119 Sheffield St. 9 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-7-1855

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>76</u>	<u>11</u>	<u>20</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (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) Ill
 10. NAME OF FATHER Joe Dunlap

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Florence A. Adams

(Address) 3901 Broadway

15. FILED 7/28/30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-27-1930

17. I HEREBY CERTIFY, That I attended deceased from 5-12- 1929, to 7-27- 1930 that I last saw her alive on 7-27- 1930, and that death occurred, on the date stated above, at 1:35-9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
186A
194B
107A (duration) yrs. mos. ds.
 CONTRIBUTORY Fracture of Rt. Hip (SECONDARY)
Fell in her home - old injury (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

8 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. B. Williams, M. D.

7-27, 1930 (Address) Supi K. B. Jewell

*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

Forest Hill Cem DATE OF BURIAL July 29 1930

20. UNDERTAKER

A. P. Dohler ADDRESS 1415 E 15

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.

CITY PHYSICIAN
OCCUPATIONAL

could be
that it

22969

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Registration District No. 399 File No.
Township Primary Registration District No. 1082 Registered No. 3119
City X City (No.) St. Ward

2. FULL NAME

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

Julia Milare

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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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)

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)

FILED 7/28, 19 20 M. M. Cerowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/27 19 20

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchopneumonia

CONTRIBUTORY (duration) yrs. mos. ds.
fracture of hip

fell on her home - old injury

(slipped and fell in home)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA

5-23/25-