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

Do not use this space.

23513

File No. ____
Registered No. ____

AUG 26 1930

1. PLACE OF DEATH
County: Macon
Township: Callao
City: ____ (No. ____, ____ St. ____ Ward)
Registration District No. 528
Primary Registration District No. 5704

2. FULL NAME: Kathryn Stacey
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	S —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 26 — 1919

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	5	13	

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) Callao
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER J B Stacey
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Macon Co
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Stella Autry
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Macon Co
(STATE OR COUNTRY) Mo

14. INFORMANT J. B. Stacey
(Address) Callao Mo

15. Filed July 11, 1930 [signature] M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1930

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1930 to July 9, 1930 that I last saw him alive on July 8, 1930 and that death occurred, on the date stated above, at 7:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
110 A
107 A Emphysema
(Purulent Pleurisy)
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) Pneumonia fever
(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? Phys Exam.
(Signed) [signature], M. D.
7/10, 1930 (Address) Callao 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: Mt Salem Cem.
DATE OF BURIAL: July 11 1930
20. UNDERTAKER: Albert Skinner
ADDRESS: Macon

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.

Brookfield
Columbia Mich

C. L. R A - J H Kan

J. C. -

Marie Dennis - Nav C -

Elmer Marshall - Overland Mo. T -

Lottie Sloop -

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B. 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.

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

1. PLACE OF DEATH

County Macon — Registration District No. 528 — File No. .....

Township Callao — Primary Registration District No. 3704 — Registered No. .....

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

2. FULL NAME Kathryn Stacey

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	S

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 July 11, 1930 W. Welch MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... 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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Lynchs Pneumonia Fever

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 1000
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

S-23513