

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**

Do not use this space.

25950

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township Washington Primary Registration District No. 1001
 City St. Joseph (No. Missouri Methodist Hosp) Ward 945

File No. _____
 Registered No. 945

2. FULL NAME

(a) Residence. No. 3011 B. Joseph Ave. Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 50 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>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Jno. W. Polley</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 9 1870</u>		
7. AGE	YEARS <u>60</u>	MONTHS <u>4</u>
	DAY <u>8</u>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>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) <u>Illinois</u>		
PARENTS	10. NAME OF FATHER <u>William Blakeley</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN). (STATE OR COUNTRY) <u>Unknown Indiana</u>	
	12. MAIDEN NAME OF MOTHER <u>Elizabethterbury</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN). (STATE OR COUNTRY) <u>Unknown Illinois</u>	
14. INFORMANT Address <u>Mrs. Char. H. Weisbach Macon, Mo.</u>		
15. FILED <u>18</u> 19 <u>30</u> <u>John G. Utz</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at 13:30 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Intestinal Obstruction
126-A
122-B (duration) _____ yrs. mos. 5 ds.
 CONTRIBUTORY (SECONDARY) Ventral Hernia
Booze (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Illinois
 IF NOT IN PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Aug 12 1930
 WAS THERE AN AUTOPSY? No
 WHO TEST CONFIRMED DIAGNOSIS? Operative Clinice
Emption Calyl Piles M. D.
 (Address) 734 Fairon

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>Macon, Mo.</u>	DATE OF BURIAL <u>Aug 18 1930</u>
20. UNDERTAKER <u>E. R. Sidenfaden</u>	ADDRESS <u>602 10th</u>

