

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.

ACT 29 1930

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

Do not use this space.

1. PLACE OF DEATH

County Jasper Registration District No. 417
 Township Webb City Primary Registration District No. 3071
 City Webb City (No. _____) St. _____ Ward _____

File No. 30293
 Registered No. 117

2. FULL NAME

Mahalk Malinda Carpenter
 (a) Residence. No. 127 N. Roane 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>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>J. S. Carpenter</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb 4, 1849</u>		
7. AGE YEARS <u>81</u>	MONTHS <u>7</u>	DAYS <u>21</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House wife</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) Illinois

PARENTS	10. NAME OF FATHER <u>Albartus Lofton</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Illinois</u>
	12. MAIDEN NAME OF MOTHER <u>Malinda Chappel</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Lincolnshire England</u>	

14. INFORMANT Maudie Carpenter
 (Address) Webb City, Mo

15. FILED 9/21 1930 R. M. Stovum
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Sept 25, 1930 that I last saw h. or alive on Sept 24, 1930, and that death occurred, on the date stated above, at 3:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Influenza

11B (duration) _____ yrs. _____ mos. 12 ds.

CONTRIBUTORY (SECONDARY) 11B (duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) George W. Cox, M. D. O.
9/21 1930 (Address) Webb City, 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 Hope DATE OF BURIAL Sept 26 1930

20. UNDERTAKER Steele Und. Co ADDRESS Webb City Mo

