

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

30490

1. PLACE OF DEATH

County Marion
Township Paxon
City Paris

Registration District No. 543
Primary Registration District No. 5734

File No. 6
Registered No. 6
St. Mo Ward 11

2. FULL NAME

(a) Residence. No. Paris Mo RR St. Mo Ward 11
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 1890

7. AGE YEARS 39 MONTHS 9 DAYS — IF LESS than 1 day, — hrs. — or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) MO
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Mark Vaughan

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

12. MAIDEN NAME OF MOTHER Abnetta Ellis

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

14. INFORMANT Mark Vaughan
(Address) Meta Mo

15. Sept 16 1930 Emma Curtman
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1930, to Sept 15 1930, that I last saw him alive on Sept 15 1930, and that death occurred, on the date stated above, at 8 30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Puerperal
Eclampsia

CONTRIBUTORY (SECONDARY) 148

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

(DID AN OPERATION PRECEDE DEATH? no DATE OF —)

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr H W Curtman M. D.
9-15 1930 (Address) Paris Mo RR

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Rowden Cemetery

9-16 1930

20. UNDERTAKER

ADDRESS

H H Stroy

Meta Mo

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Sl..... Ward.....
 Length of residence in city or town where death occurred yrs. mos. da. (If nonresident give city or town and State) yrs. mos. da.

2. FULL NAME

(a) Residence, No..... Sl..... Ward.....
 (Usual place of abode) mos. da. (If nonresident give city or town and State) yrs. mos. da.
 Length of residence in city or town where death occurred yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. 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).....

PARENTS

14. INFORMANT..... (Address).....

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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:

CONTRIBUTORY..... (duration)..... yrs. mos. da.

(SECONDARY)..... (duration)..... yrs. mos. da.

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS.....