

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

Do not use this space.
31276

1. PLACE OF DEATH

County.....
Township.....
City..... (No.)

Registration District No. **701**
Primary Registration District No. **1003**

File No. **8871**
Registered No. **8871**
St. **24th** Ward)

2. FULL NAME

Myrtle Renfro
(a) Residence No. **2618 Thomas** St. **7** Ward.

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** *Colored* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Single*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *11/14/1905*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,	
				hrs.	or min.
	<i>25</i>	<i>7</i>	<i>25</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Housework*
(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) *(Ames) Mo*

10. NAME OF FATHER

Clark Renfro

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER

Alice Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo*

14.

INFORMANT..... *Joe Kaffler*
(Address) *ISOLATION HOSPITAL*

15.

FILED **11 1930** *Wm E Starker*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-8-1930*

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 4, 1929, to Sept. 8, 1930*
that I last saw her alive on *Sept. 18, 1930*, and that death occurred, on the date stated above, at *4:25 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs
9:30 A.
(duration) *1* yrs. *1* mos. ds.

CONTRIBUTORY (SECONDARY)

31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... *?*

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Bacillus in Sputum*

(Signed) *Thomas J. [unclear] M. D.*

9-8-1930 (Address) **ISOLATION HOSPITAL**

*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**

Father deacon con *9-10 1930*

20. UNDERTAKER **ADDRESS**

E. Scott 3015 Taylor

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Handwritten scribble or signature at the top center of the page.