

NOV 21 1930

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

Do not use this space.

32230

1. PLACE OF DEATH

County

Butler

Registration District No.

89

File No.

Township

Paplar Bluff

Primary Registration District No.

5131

Registered No.

189

City

No.

St.

Ward)

2. FULL NAME

Mary Marie Holt

(a) Residence, No.

(Usual place of abode)

1 1/2 mi So Paplar Bluff Mo. Ward.

(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

Female

4. COLOR OR RACE

White

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

—

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

—

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

May 24 - 1930

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

—

4

9

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

182
159

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Butler Co Mo

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Hannah Holt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Paplar Bluff
Butler Co Mo

14.

INFORMANT

Drew G. Holt

(Address)

Paplar Bluff Mo. General

15.

FILED

10-31-30

B. H. Claus

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 3rd 1930

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to

....., 19.....

that I last saw him alive on 19....., and that death occurred, on the date stated above, at

3:00

a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Did not see child but from information I can gather I believe death was due to suffocation (duration) yrs. mos. ds. weak and delicate undernourished death (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) accidental death

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)

Thorel Green Coroner M. D.

10/3 . 1930 (Address)

Paplar Bluff 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

DATE OF BURIAL

Williard Cemetery

Oct 4 1930

20. UNDERTAKER

ADDRESS

A. P. Phelps Paplar Bluff Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Butler Registration District No. 89 File No. _____
 Township Dexter Primary Registration District No. 3131 Registered No. 189
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

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

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

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

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

Did not see child, but from information believe death was due to suffocation by cover on bed
 (duration) _____ yrs. _____ mos. _____ ds.
 ACCIDENTAL DEATHS
 (SECONDARY)

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 _____

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)

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) _____

14. INFORMANT _____
 (Address) _____

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

15. Oct 18 1930 J. Cline
 REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHOULD RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF CAUSE OF DEATH IN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH IN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

SUPPLEMENTARY

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