

NOV 28 1930

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

Do not use this space.

33922

1. PLACE OF DEATH

County St. Clair
Township Collins
City Ida (No. Francis)

Registration District No. 762
Primary Registration District No. 6003

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(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 widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 - 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 4 7

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Henry Carpenter

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

12. MAIDEN NAME OF MOTHER Melissa Lewis

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

14. INFORMANT A. Francis
(Address) Humansville, Mo.

15. FILED Nov 17, 1930 Miss C. L. Landecker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. - mos. - ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

3. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct 15 - 1929

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Microscopic
(Signed) A. J. Stuppelmann, M. D.

10-17-1930 (Address) Humansville 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

Humansville Mo

Oct. 17 1930

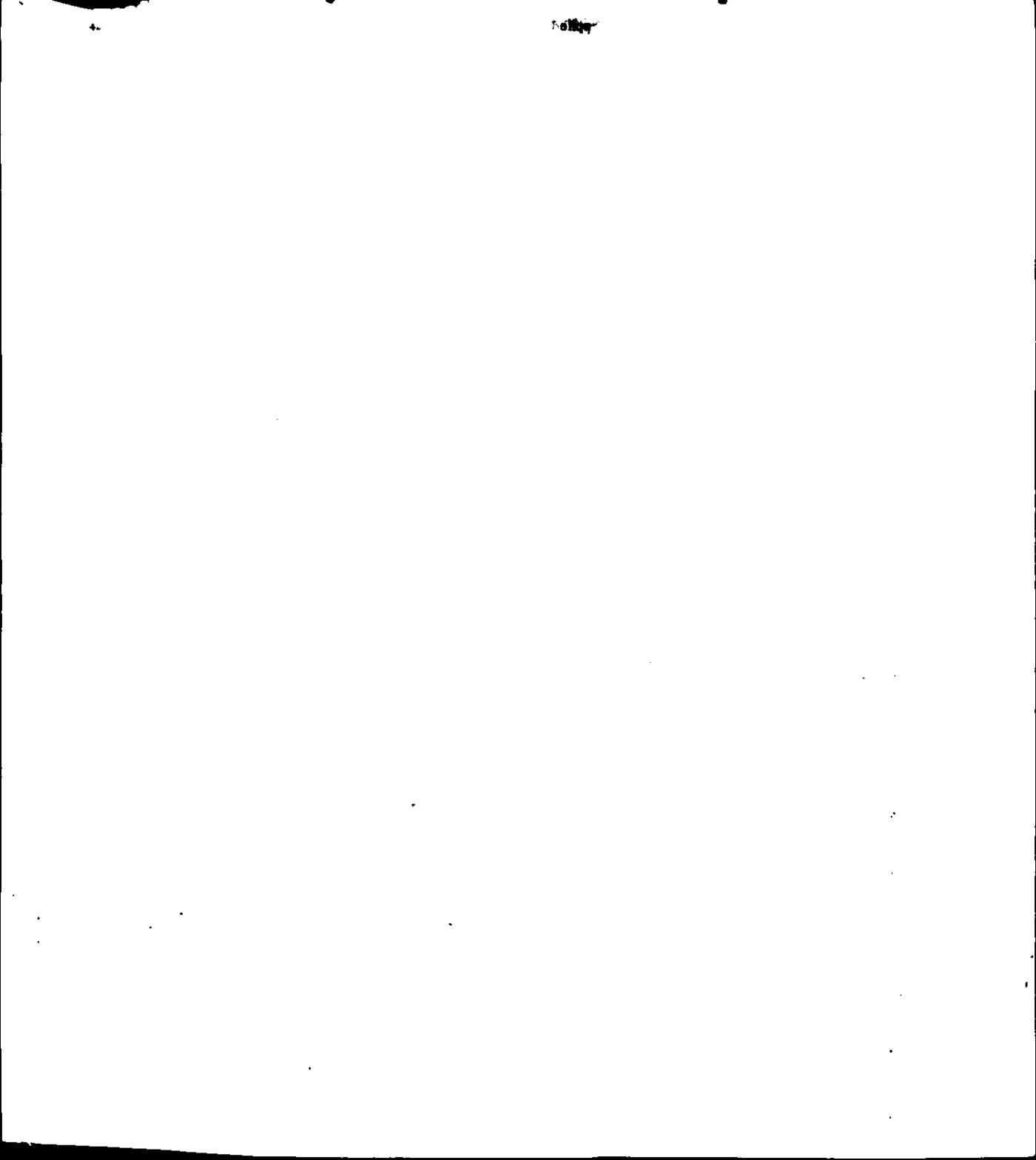
20. UNDERTAKER

ADDRESS

J. K. Pircetone

Collins Mo

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Clair
Township Collins
City (No.) St. Ward

Registration District No. 762
Primary Registration District No. 6003

File No.
Registered No.

2. FULL NAME

John Francis

(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

3. SEX

M

4. COLOR OR RACE

W

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

M

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

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

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

14.

INFORMANT (Address)

15.

FILED 10-17-30 Mrs. C. L. Landaker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 15 1930

17.

I HEREBY CERTIFY That I attended deceased from 19....., 19.....

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cardiomegaly Uterus

CONTRIBUTORY (SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33922