DEC 29 1930

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

Do not use this space.

35762

1. PLACE OF DEATH

County: Dunklin — Registration District No.: 283 — File No.: 130

Township: ~~Cardwell~~ Buffalo — Primary Registration District No.: 5402 — Registered No.:

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Magdeline Jewel Koons

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 11th, 1930

7. AGE — YEARS: — MONTHS: 2 DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home
(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): Ins.

PARENTS

10. NAME OF FATHER: Frank B Koons

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

12. MAIDEN NAME OF MOTHER: Nana Cathrine Harman

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

14. INFORMANT: Fred Harman
(Address): Ashford Mo. RFD 1

15. FILED 11-9, 1930 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 9 1930

17. I HEREBY CERTIFY, That I attended deceased from 11/8 1930 to 11/8 1930 that I last saw her alive on 11/8 1930, and that death occurred, on the date stated above, at 2:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
10 yr. 11
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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) G. Kimbrough, M. D.

11/9, 1930 (Address) Ashford 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: Paragould Ark — DATE OF BURIAL: 11/9 1930

20. UNDERTAKER: Howard & Lindsey — ADDRESS: Cardwell Mo.

N. B.—Blanks should be filled out in ink and be signed. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated in terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin Registration District No. 283 File No.

Township Buffalo Primary Registration District No. 5402 Registered No. 130

City (No. , St. Ward)

2. FULL NAME Mayeline Jewel Kvars

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

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

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)

PARENTS
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 11-9, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 9 1930

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:
Pneumonia
Broncho,

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1000

(duration) yrs. mos. ds.

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B.—E[illegible] DEATH in plain [illegible] should but it may [illegible] AGI[illegible] [illegible] state [illegible] PHYSICIANS should state CAUSE [illegible] OCCUPATION is very important.

REGISTRAR [illegible] CERTIFICATES UNT[illegible] Y AR[illegible] [illegible]LETE AS PRESCRIBED BY LAW

S-35742