DEC 22 1930

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

Do not use this space.

36688

File No. .....
Registered No. 55

1. PLACE OF DEATH

County: Lewis
Township: Canton
City: Canton (No. ....., 4266 St. ..... Ward)

Registration District No. 477
Primary Registration District No. 4266

2. FULL NAME Mary Ann Underbrink

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18 - 1847

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	9	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(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) Burmingham England

PARENTS

10. NAME OF FATHER William Newman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) England
12. MAIDEN NAME OF MOTHER Margaret Bray
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) England

14. INFORMANT Mr. Will Underbrink
(Address) Lewistown Mo

15. FILED 12-1, 1930 H. W. Harris M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 29, 1930, that I last saw her alive on Nov 29, 1930 and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchio Pneumonia
..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Fracture of Femur
..... (duration) ..... yrs. ..... mos. 16 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) J. J. Hillard M.D.
, 19 (Address) Canton

*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: Forest Grove - Canton, Mo
DATE OF BURIAL: Dec 1 1930

20. UNDERTAKER: F. D. Kelly
ADDRESS: Canton Mo.

N. B.—Every item on this certificate should be answered, if possible. Any item not known should be so stated. 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: Lewis — Registration District No.: 477 — File No.:
Township: — Primary Registration District No.: 4266 — Registered No.: 35
City: Canton (No. ..., ..., St. ..., Ward)

2. FULL NAME: Mary Ann Vandenbrink
(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.

N. B. — Any ... of information ... A ... Physicians should state CAUSE OF DEATH ... Exact statement of OCCUPATION is very important. Check ... so properly classified.

REGISTRAR'S FEE FOR CERTIFIED COPY UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PERSONAL AND STATISTICAL PARTICULARS

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

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 1-9 1931 H. W. Harris M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 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:
Bronchial Pneumonia
... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) Fracture of hip joint
Slipped on wet floor in the kitchen & sustained fracture
... (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

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