

DEC 22 1930

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

Do not use this space.
36767

1. PLACE OF DEATH

County Madison
Township St. Michael
City Isabella (No. 5723)

Registration District No. 538
Primary Registration District No. 0723

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

2. FULL NAME Isabella White

(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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 11 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mineral Point Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Thos. Kilbey
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Isabelle McFadden
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Pauline White
(Address) Fredericktown Mo.

15. Nov 21 1930 C. U. Quast
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1930, to Nov 20 1930, that I last saw him alive on Nov 20 1930, and that death occurred, on the date stated above, at 6:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
(duration) _____ yrs. _____ mos. 9 ds.

CONTRIBUTORY Chronic nephritis
(SECONDARY) (duration) 1 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Not at place of death

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. K. Langston, M. D.

(Address) Fredericktown 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 Calvary Ave. City DATE OF BURIAL Nov 22 1930
20. UNDERTAKER Ed. H. Webb, Fredericktown Mo. ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Do not certify supplied. Do not certify supplied.

