

2.4 1931

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

1. PLACE OF BIRTH

County Greene
Township Benton
City..... (No.....).....

Registration District No. 230
Primary Registration District No. 3312

File No. 680
Registered No. 219
St. Ward)

2. FULL NAME

Mary O'Fallon

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Malachy O'Fallon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16-1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
90 5 27

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) (STATE OR COUNTRY) Ireland

10. NAME OF FATHER Donley

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

12. MAIDEN NAME OF MOTHER —

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

PARENTS

14. INFORMANT William O'Fallon
(Address) Leasburg Mo

15. FILED Jan 20 31 W. H. Train M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/12-1931

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..... 9-15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial Insufficiency
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) W. H. Train
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF BIRTH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

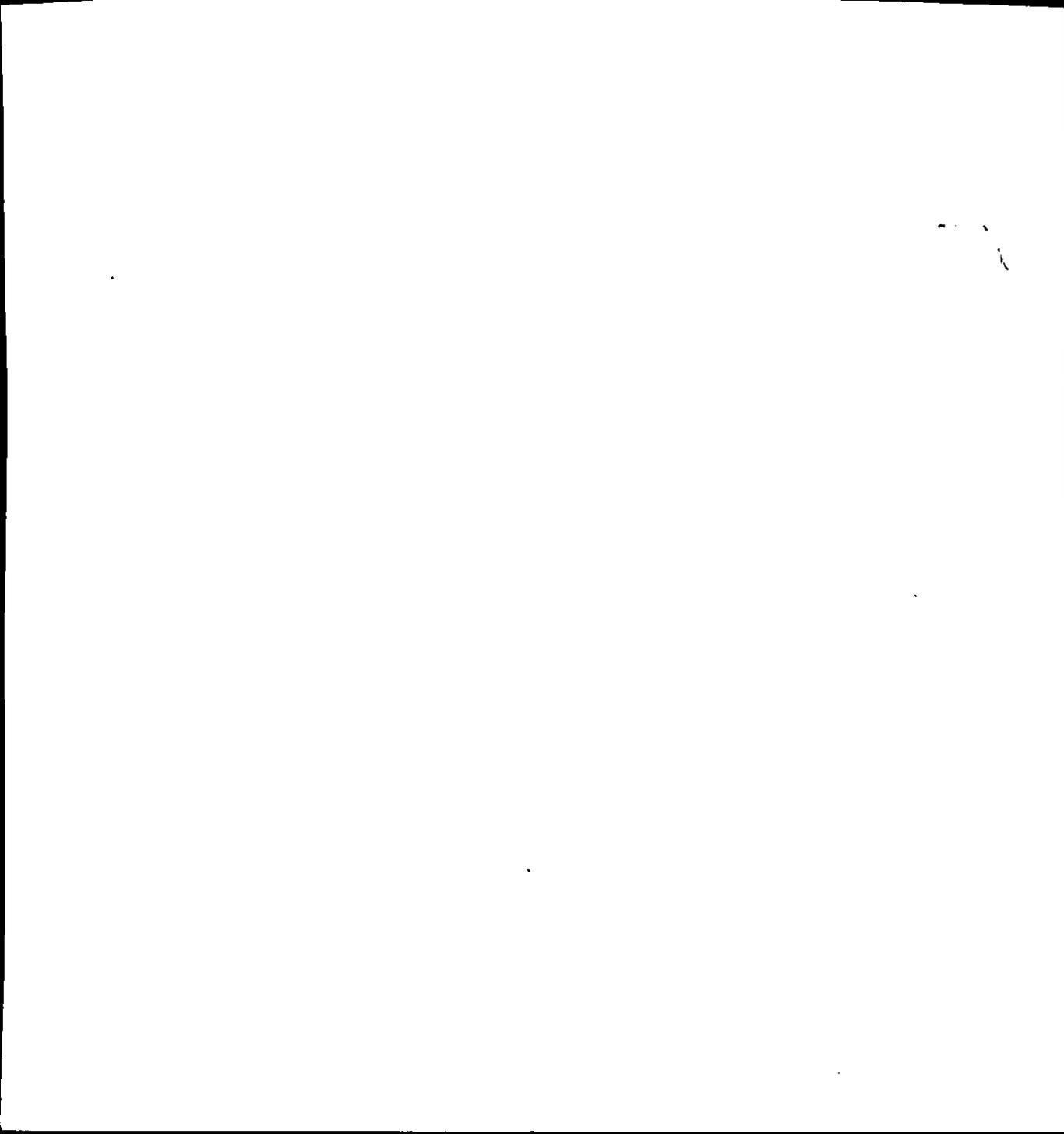
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) W. H. Train, M. D.
Jan 20 31 (Address) Leasburg 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
Catholic Cemetery Leasburg 1/14 1931

20. UNDERTAKER ADDRESS
L. J. Jones Steelville 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 Crawford
Towship Benton
City (No. _____) _____

Registration District No. 230
Primary Registration District No. 3312

File No. _____
Registered No. 219
St. _____ Ward _____

2. FULL NAME

Marij O'Fallon

(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) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Malachey O'Fallon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16 - 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
90 7 26

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)

(STATE OR COUNTRY) Ireland

10. NAME OF FATHER Douglas

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT William O'Fallon
(Address) Leasburg mo.

15. FILED 4/1/31 G. G. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jun 12 1931

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 _____ 7-15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Coronary Insufficiency

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ 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? Clinical

(Signed) W. F. Travis, M. D.

120, 1931 (Address) Leasburg 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
Catholic Ceme 1-14 1931

20. UNDERTAKER ADDRESS
Leasburg
L. J. Jones Steelville mo.

SUPPLEMENTARY

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

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