

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

Do not use this space.

925

File No. _____
Registered No. 29
St. _____ Ward _____

PLACE OF DEATH

County Linn Registration District No. 518
Township _____ Primary Registration District No. 2001
City Springfield (No. 704 N. Grant)

2. FULL NAME

ella Mallory
(a) Residence. No. 704 N. Grant Ave. Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Carl Mallory

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 15, 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or mls.
40 4 25

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 2

10. NAME OF FATHER M. E. Lunsford

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

12. MAIDEN NAME OF MOTHER Margaret Lunsford

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

14. INFORMANT Carl Mallory
(Address) 704 N. Grant

15. FILED 12, 1931 Gene Sharp REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-10-31

17. I HEREBY CERTIFY That I attended deceased from 1-10-31 to 1-10-31 that I last saw her alive on 1-10-31 and that death occurred, on the date stated above, at 1:20 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Confinement
14 1/2 Consequence of labor (duration) 14 1/2 mos. ds.
1 1/2 Anaemia Debility (duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTACTED IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) F. E. Armstrong, M. D.
112. 1/2 (Address) Springfield 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 Indianapolis Ind. DATE OF BURIAL 1-14-31

20. UNDERTAKER W. H. Clark ADDRESS W. H. Clark

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FEB 20 1931

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