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

Do not use this space.

988

File No. .....

Registered No. 2

1. PLACE OF DEATH

County: Green — Registration District No. 321

Township: Clay — Primary Registration District No. 32044

City: Galloway MO (No. ..... R.R. ..... St. ..... Ward)

2. FULL NAME: Talitha Susan McMullen

(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: Female

4. COLOR OR RACE: White

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

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: G. H. McMullen

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 9th 1857

7. AGE: Years 73 | Months [illegible] | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 235
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

PARENTS

10. NAME OF FATHER: Green Reynolds

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

12. MAIDEN NAME OF MOTHER: Ee. Singleton

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

14. INFORMANT: G. H. McMullen
(Address): Galloway MO, R.R.

15. FILED 1/21, 1931 — M. L. Turner, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 19. 1931

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h. alive on Jan 19, 1931, and that death occurred, on the date stated above, at 3:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ill B
1 Coronary Sclerosis
2 hr
..... (duration) ..... yrs. ..... mos. ..... ds.

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? .....

(Signed) Norman C. Stone Coroner M. D
Jan 19, 1931 (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: Hope Dale Cemetery — DATE OF BURIAL: Jan 22 1931

20. UNDERTAKER: F. B. Cheffin — ADDRESS: Ozark Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.