

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

Do not use this space.

12778

1. PLACE OF DEATH

County Saline
Township Arrow Rock
City Arrow Rock (No.)

Registration District No. 792
Primary Registration District No. 6035

File No.
Registered No.
St. Ward

2. FULL NAME

Isabel Serier

(a) Residence. No. St. Ward.
(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. (If nonresident give city or town and State)

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

Ulysis Serier

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

Feb. 18-1861

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

70 0 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(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)

Mo.

10. NAME OF FATHER

Milton Malotte

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Mary J. Moon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT
(Address)

Walker Serier
Arrow Rock Mo.

15.

FILED 3-20, 1931

C. L. Lavelles
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

March 15 1931

17.

I HEREBY CERTIFY, That I attended deceased from all 1928 to March 14 1931, that I last saw her alive on March 14 1931, and that death occurred, on the date stated above, at 1:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic pneumonia

720

820

1115

(duration) 7 yrs. mos. ds.

CONTRIBUTORY Paralysis

(SECONDARY)

(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) B. B. Bradshaw, M. D.

3-15, 1931 (Address) Arrow Rock 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

Samuel Ann. March 16 1931

20. UNDERTAKER

ADDRESS

T. M. Campbell Marshall

APR 27 1931

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.

**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 Delaware
Township Arrow Rock
City Isabelle (No.)

Registration District No. 492
Primary Registration District No. 2035

File No.
Registered No.
St. Ward)

2. FULL NAME

Isabelle Sevier

(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) 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 3.2, 19 31 P. P. Lawless

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 15 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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic pneumonia
..... (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Analisis
Cerebral Hemorrhage yrs. mos. da.

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

20. UNDERTAKER

ADDRESS

19

Every item of information should be carefully supplied. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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