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

Do not use this space.

15131

MAY 27 1931

**1. PLACE OF DEATH**

County: Osage — Registration District No.: 639

Township: Belton — Primary Registration District No.: 5848

City: ..... (No. ..... St. ..... Ward)

File No.: .....

Registered No.: .....

**2. FULL NAME** Susan E. Childers

(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*) Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED** HUSBAND OF (OR) WIFE OF

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Dec. 25, 1848

**7. AGE** Years 82 Months 4 Days 2 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) Living with her two sisters)
(c) Name of employer

**9. BIRTHPLACE** (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn.

**PARENTS**

**10. NAME OF FATHER** Azel Childers

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) .....
(STATE OR COUNTRY) N. Carolina

**12. MAIDEN NAME OF MOTHER** Rebecca Rhodes

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

**14.** INFORMANT Tina Childers
(Address) Chamois, Mo.

**15.** FILED 4-28, 1931 Esther Sonder
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) Apr 27th 1931

**17.** I HEREBY CERTIFY, That I attended deceased from March 1st, 1931, to Apr 27th, 1931, that I last saw ..... alive on Apr 27th, 1931, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Endocarditis

99th

(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? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. L. Towsley, M. D.

, 19 (Address) Chamois 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** City Cemetery, Chamois, Mo — **DATE OF BURIAL** 19

**20. UNDERTAKER** F. W. Engelage — **ADDRESS** Chamois Mo.

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.

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