

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

Do not use this space.

16729

File No. _____
Registered No. 61 St. _____ Ward _____

1. PLACE OF DEATH

County Saline Registration District No. 796
Township Marshall Primary Registration District No. 3038
City Marshall (No. _____) St. _____ Ward _____

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 27 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 3 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook 2^d
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Salina, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Bertie Dismald
(Address)

15. FILED 4-12 1931 Mrs. John H. McQuire
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4th 1931

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1930, to April 4th 1931, that I last saw her alive on April 1st 1931, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular Heart Disease
48
72A

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Carcinoma Uteri

(duration) 10 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Marshall Mo.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.

(Signed) W. H. Madison, M. D.

, 19 (Address) Marshall 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

Fairview Cem April 7 1931

20. UNDERTAKER ADDRESS

Ferguson with care Marshall

RECORDS TO BE KEPT EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important.

MAY 27 1931

68-3-7

PARENTS

cc

**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 Saline Registration District No. 127 File No. _____
 Township _____ Primary Registration District No. 796 Registered No. 61
 City Marshall (No. 3038) St. _____ Ward _____

2. FULL NAME

(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 Col 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) Dec 27-1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>68</u>	<u>3</u>	<u>7</u>	<u>2</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

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) _____

FILED 4-12-1931 Mrs. John B. McGuire
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 4 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:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (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) _____, 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

19

20. UNDERTAKER

ADDRESS

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

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.

SUPPLEMENTARY

5-16729