

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

Do not use this space.

27872

1. PLACE OF DEATH

County Dade

Registration District No. 736

File No. _____

Township Everton

Primary Registration District No. 2143

Registered No. 9

City Everton (No. _____)

St. _____ Ward _____

2. FULL NAME

Alvira Ann Jerome

(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) Married

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>4</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. SAW

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. HandWip

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Everton Dade Co Mo

13. NAME Huston Washburn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MAIDEN NAME Phoebe McKeel

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) J. V. Jerome Everton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Graves DATE 8/10 1931

19. UNDERTAKER (ADDRESS) Barber & Wheeler

20. FILED 9-9 1931 W. R. Riley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-5 1931

22. I HEREBY CERTIFY, That I attended deceased from Was Dead when arrived. Only local
I last saw 5:20 am after labor, 1931. Death is said to have occurred on the date stated above, at 10:30 am.

The principal cause of death and related causes of importance were as follows:
Valvular Heart trouble Date of onset _____

92A
92A
Other contributory causes of importance: _____

Name of operation None Date of _____
What test confirmed diagnosis: Death Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1931
Where did injury occur? Home
(Specify city or town, county, and State)

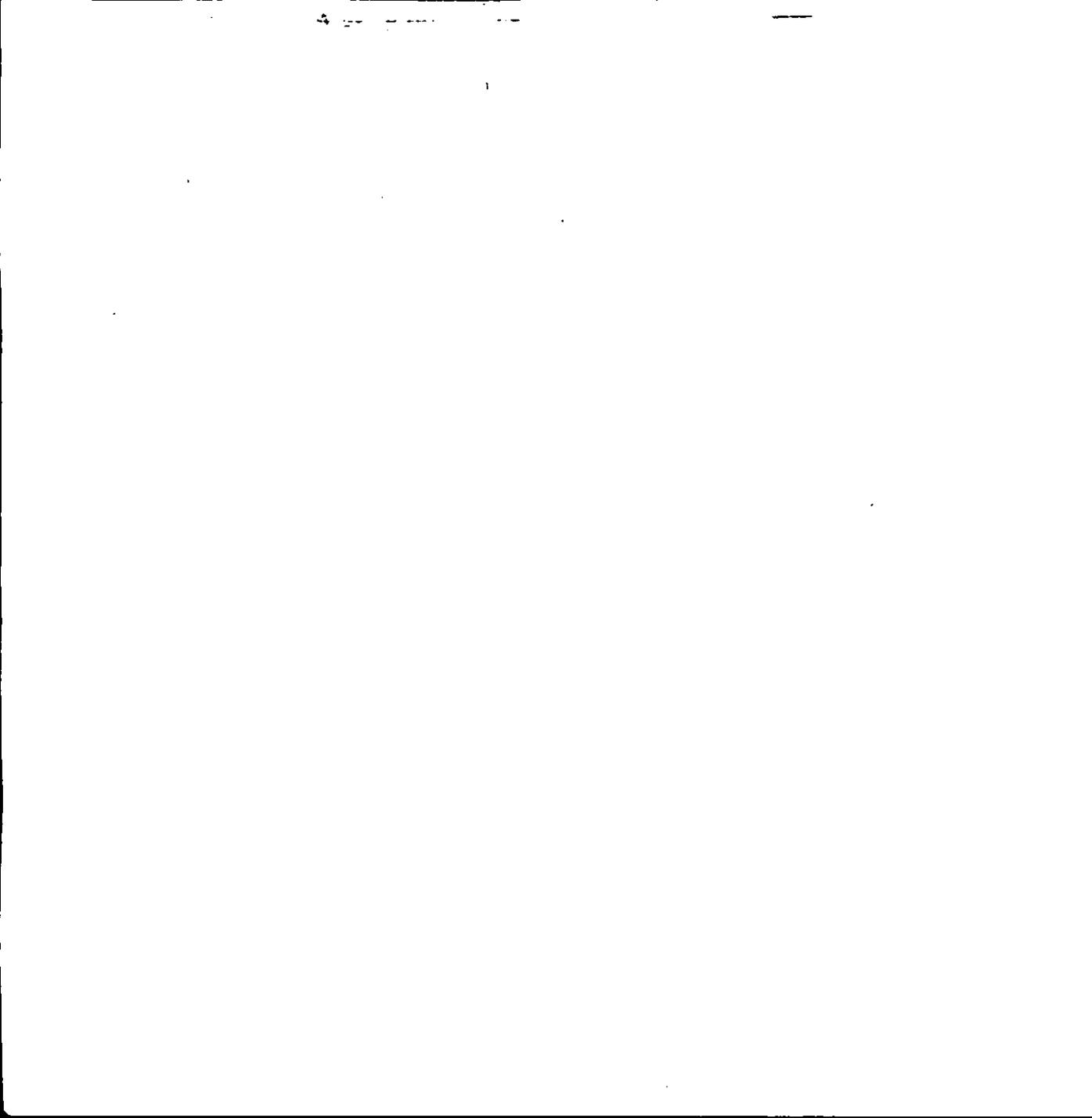
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury su

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) W. R. Riley M. D.
(Address) Everton Mo



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dade Registration District No. 236 File No. _____
Township _____ Primary Registration District No. 4143 Registered No. 9
City Everton (No. _____) St. _____ Ward _____

2. FULL NAME

Alvira Ann Jerome
(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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-13-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 4 22 = _____

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 9-9-31 1931

Dr. R. R. Reay
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 19 31

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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) _____, 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

S-27872