

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

Do not use this space.

**28134**

1. PLACE OF DEATH  
 County Linn Registration District No. 382  
 Township \_\_\_\_\_ Primary Registration District No. 4227  
 City West Plains, Mo. St. \_\_\_\_\_ Ward) \_\_\_\_\_  
 2. FULL NAME Alberta Kay  
 (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 FW 4. COLOR OR RACE Wht 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) January 17  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
28  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 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) Henderson, Ark.  
 13. NAME Mrs. F. Cap  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atlanta, Ga.  
 15. MAIDEN NAME Jeanette Henderson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henderson, Ark.  
 17. INFORMANT (ADDRESS) Mrs. Jeanette Cap West Plains, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Home at Viola Ark 8/10 DATE 1931  
 19. UNDERTAKER (ADDRESS) McFarland's West Plains, Mo.  
 20. FILED 8-10 19 31 O.P.A. Reimick Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/8 19 31  
 22. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1931, to Aug 8, 1931  
 I last saw her alive on Aug 3, 1931 Death is said to have occurred on the date stated above, at 6:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic parenchymatous nephritis  
 Date of onset 131  
 Other contributory causes of importance: 131  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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 \_\_\_\_\_, 19 \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) E. Clarence Cochran M. D.  
 (Address) West Plains, Mo.

SEP 28 1931

31.8.5  
28 1.17

1903-6-21

**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 Howell Registration District No. 384 File No. ....  
Towship ..... Primary Registration District No. 4227 Registered No. 110  
City West Plains 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 1903

7. AGE YEARS MONTHS DAYS (If LESS than 1 day, hrs. or min.)  
28 6 21

**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)

15. FILED 8-10-31 1931 O.P. Heinrich  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/8 1931

17. I HEREBY CERTIFY That I attended deceased from .....  
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.

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

SUPPLEMENTARY

5-28134