

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

Do not use this space.

28496

362A

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kennett Primary Registration District No. _____
City Kennett (No. 4012 E. 17th) St. _____ Ward _____

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

2. FULL NAME

(a) Residence. No. 4012 E. 17th St. 12 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Leol
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nathan Bibbs
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 29, 1837
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 94 - 6
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hopkinsville (STATE OR COUNTRY) Ky
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER Mary Wheatley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Lillian Armstrong (Address) 4012 E. 17th St
15. FILED 29, 31 1931 M.M. Carver REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. - 26 - 31
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:

Accidental Fall
Fractured Hip
1915 (duration) _____ yrs. mos. ds.
CONTRIBUTORY Pneumonia, lobar (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____
19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical History
(Signed) W. Carver M. D.

*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 Independence, Mo. DATE OF BURIAL Aug. 29, 1931
20. UNDERTAKER Watkins, Bros. ADDRESS 2002 E-12th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. 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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of the state

REVIN

1942

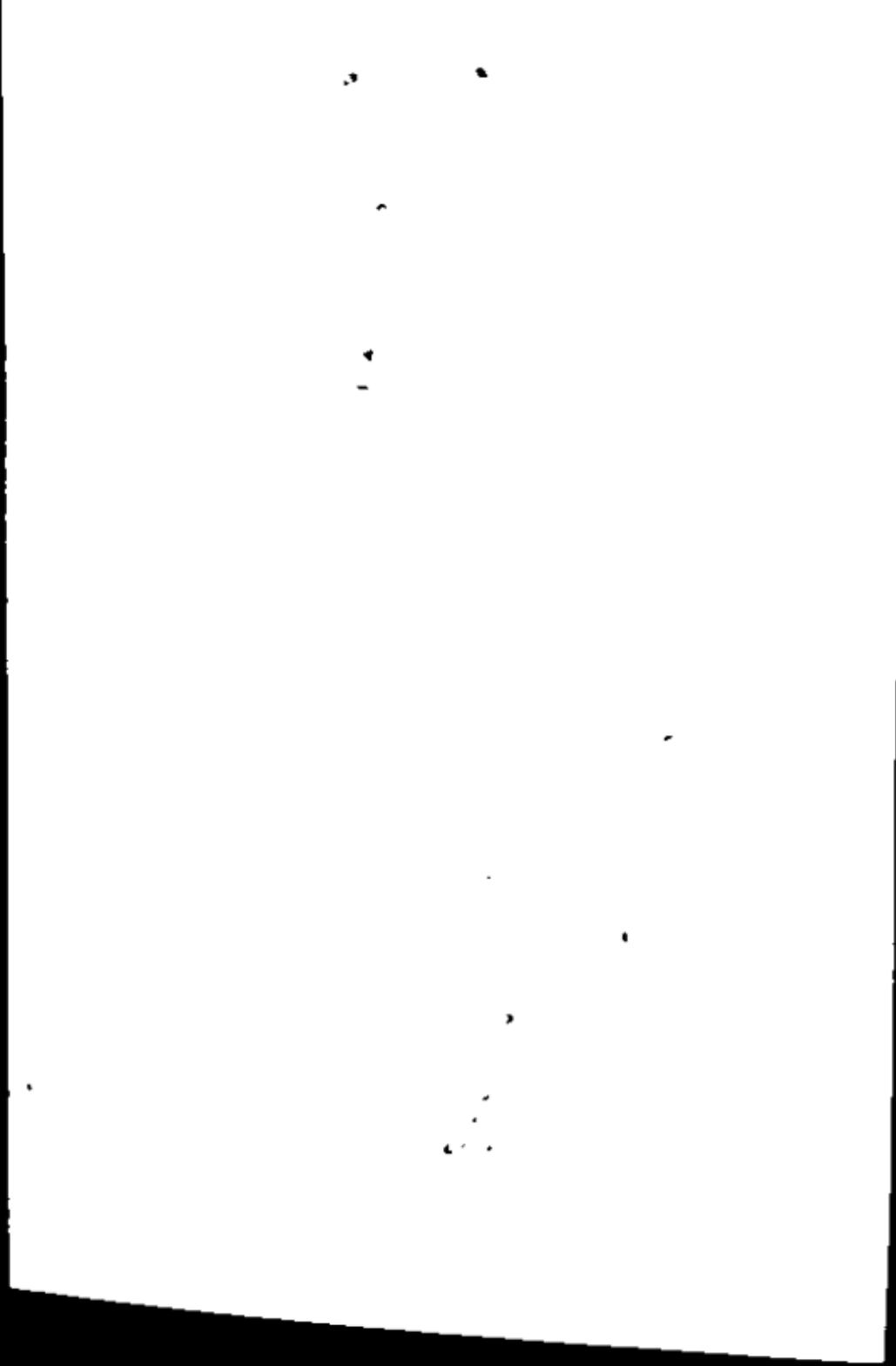
JUN 5 1943

S (2) # 28496

Was this fall
in home?

Was fall down
a stairway?

Fell down Stairs at Home
two times



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 379 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 3624
 City X. City (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. 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)

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)

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 29 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental fall fractured hip
 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... Pneumonia lobar
 (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

20. UNDERTAKER ADDRESS

PHYSICIANS should state EXACTLY OCCUPATION is very important. AGE should be stated EXACTLY. AGE should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. REG.

SUPPLEMENTARY

S- (2) - 28496