

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

Do not use this space.

28631

1. PLACE OF DEATH

County Jackson
Township West City
City West City (No.) St. Ward)

Registration District No. 417
Primary Registration District No. 3021

File No.
Registered No. 81

2. FULL NAME

Miss Mary Alice Magruder
(a) Residence, No. 24 W 3rd St., Ward 1
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 3 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 4410

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 531

10. Date deceased last worked at this occupation (month and year) 1931 11. Total time (years) spent in this occupation 76

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Mo.

13. NAME John P. Poudal

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

15. MAIDEN NAME Louisa James

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT (ADDRESS) Magruder West City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Carmel DATE 9/2 1931

19. UNDERTAKER (ADDRESS) West City Mo.

20. FILED 9/1 1931 R. M. Starnont Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 31 1931

22. I HEREBY CERTIFY that I attended deceased from 1:50 8/31 to 11:31 1931
I last saw him alive on 8/30 1931. Death is said to have occurred on the date stated above, at 2:30 P. m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of P. groin & Vagina Date of onset
Chronic Pharyngitis

Other contributory causes of importance
Labrodex Name of operation Date of 3/31
(What test confirmed diagnosis? Labrodex Was there an autopsy?)

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?
If so, specify Chronic Pharyngitis
(Signed) R. M. Starnont M. D.
(Address) West City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. OCT 24 1931

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Josper Registration District No. 417 File No. _____
 Township _____ Primary Registration District No. 3021 Registered No. 81
 City Webb City (No. _____) St. _____ Ward _____

2. FULL NAME

Mary Alice Magruder
 (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) wid
 5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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. FILE NO. 11931 REGISTRAR R. M. Stormont

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/31 19 31
 17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive _____, 19____, and that death occurred, on the date stated above of _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cardiomyopathy
P. & A. (Primary seat was valvular)
 CONTRIBUTORY (duration) _____ yrs. _____ mos. _____ ds.
Chronic Rheumatism
 (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? 49
 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 _____

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESC. AW. INFORMATION SHOULD BE EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION IS TO BE IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

S-28631