

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

Do not use this space.

**29240**

**1. PLACE OF DEATH**

County St. Francois  
Township Randolph  
City Desloge (No. ....)

Registration District No. 779  
Primary Registration District No. 6024A

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

**2. FULL NAME**

Mary Ledbetter

(a) Residence, No. Desloge mo. St. .... Ward. ....

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) divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 15 - 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>70</u>	<u>5</u>	<u>12</u>	

OCCUPATION

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

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) Tennessee

FATHER

13. NAME Pete Smith

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

MOTHER

15. MAIDEN NAME Martha Watkins

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

17. INFORMANT (ADDRESS) Mrs. J. B. Kelley Desloge Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Doerun DATE Aug. 29 1931

19. UNDERTAKER (ADDRESS) C. J. Boyer Desloge Missouri

20. FILED Aug. 29 1931 R. B. Porter Registrar.

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 27 1931, to Aug 27 1931. I last saw her alive on Aug 27 1931. Death is said to have occurred on the date stated above, at 3:30 P.M.

The principal cause of death and related causes of importance were as follows:

Angina Pectoris Date of onset 8/27/31  
91A  
118C 94W

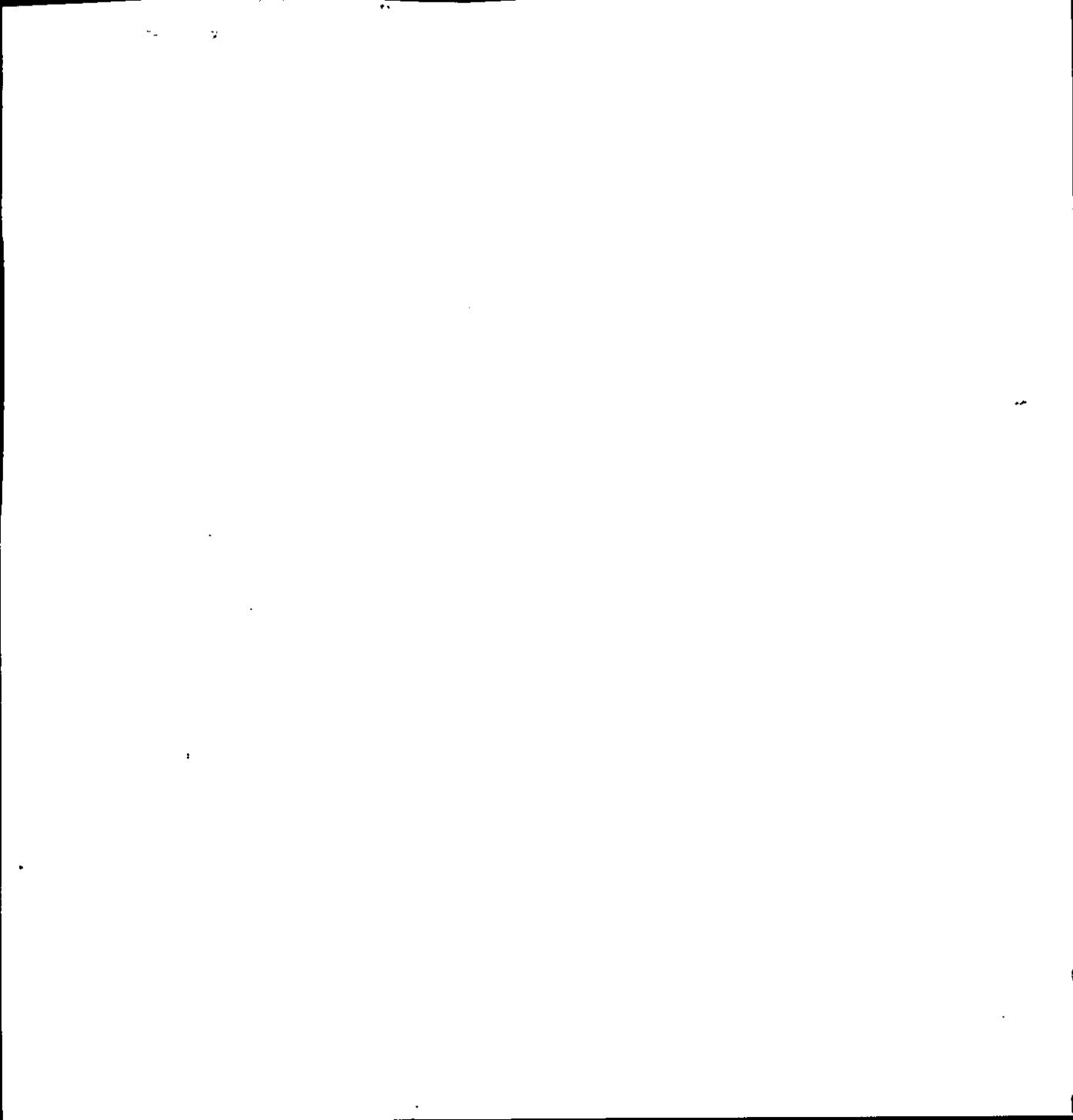
Other contributory causes of importance: Acute Indigestion 8/27/31

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... 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? no  
If so, specify .....  
(Signed) E. B. Rohrbach, M. D.  
(Address) Flax River, Mo.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Francois Registration District No. 779 File No. ....  
 Township Randolph Primary Registration District No. 6642 Registered No. ....  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

Mary Redbetter  
 (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) Div.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 15 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 5 19

**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)  
 (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 8-29-31 R. B. Hester REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 19 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 .....

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

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

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

S-29240