

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

Do not use this space.

1. PLACE OF DEATH

County Saline
Township Maltabend
City Blower (No. _____)

Registration District No. 795
Primary Registration District No. 6038

File No. 30229
Registered 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 Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4 / 8 9 0

7. AGE	YEARS	MONTHS	DAYS	IF LESS (than 1 day, _____ hrs. or _____ min.)
	<u>41</u>	<u>2</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Laclede mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Wyotte price

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Laclede mo

12. MAIDEN NAME OF MOTHER Matha Thomas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Maltabend mo

14. INFORMANT Louise price
(Address)

15. FILED 8-21, 1931 Mrs. Mary Blackburn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20th 1931

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1931, to Aug 20th 1931, that I last saw her alive on Aug 19th 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Interstitial Nephritis

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, Don't know

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.
(Signed) W. D. Madison, M. D.

8-20, 1931 (Address) Marshall mo

*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 Saltpond bur DATE OF BURIAL Aug 22 1931

20. UNDERTAKER Reynolds Williams ADDRESS Marshall

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.

SEP 28 1931

