

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

Do not use this space.

30389

1. PLACE OF DEATH

County Texas Registration District No. 868 File No. _____
 Township Sherrill Primary Registration District No. 6179 Registered No. _____
 City _____ (No. 2) St. _____ Ward _____

2. FULL NAME

Mary Caroline Amber
 (a) Residence, No. _____ St. _____ Ward _____
 (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) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/11/1911
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 20
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 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) Texas Co mo

13. NAME David Amber

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas Co mo

15. MAIDEN NAME David Nelson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas Co mo

17. INFORMANT (ADDRESS) David Amber

18. BURIAL, CREMATION, OR REMOVAL PLACE Boon Creek DATE 8-16-31

19. UNDERTAKER (ADDRESS) W. C. Smith

20. FILED 8-16-31 Ray G. Huse Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15-1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1931, to Aug 16, 1931
 First saw her alive on Aug 15, 1931. Death is said to have occurred on the date stated above, at 7 a.m.
 The principal cause of death and related causes of importance were as follows:

Illie Colitis
1198
119
 Other contributory causes of importance: _____
 Date of onset _____

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? _____
 If so, specify _____

(Signed) W. C. Smith, M. D.
 (Address) Boon Creek, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. **SEP 8 1931**

**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 Texas
Township Sherrill
City (No.)

Registration District No. 868
Primary Registration District No. 6149

File No.
Registered No.
St. Ward

2. FULL NAME

Mary Caroline Ambers
(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 S. (write the word)

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. 20 11 11

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 , 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15 19 31

17. I HEREBY CERTIFY That I attended deceased from , 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

DEATH RECORD

Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBE.

SUPPLEMENTARY

S-30339