

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

Do not use this space.

701

33239

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No. ....)

File No.....

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 3 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
abt. 60 - - -

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. Dept

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk

13. NAME unknown

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

15. MAIDEN NAME unknown

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

17. INFORMANT A. R. Stange (ADDRESS) City, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Little Rock Ark DATE Oct 2 1931

19. UNDERTAKER Dennis & son (ADDRESS) 2700 Wash St

20. FILED UCI - 2 1931 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-29 1931

22. I HEREBY CERTIFY, That I attended deceased from 7-14 1931 to 9-29 1931

I last saw h. alive on 9-29-1931 Death is said to have occurred on the date stated above, at 1:00 m.

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

gall  
chronic myocardial 5 years  
Other contributory causes of importance:  
930

Name of operation..... Date of.....  
What test confirmed diagnosis? 9/29/31 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) C. M. Smith #....., M. D.  
(Address) City, Missouri #2

