

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

Do not use this space.

33286

1. PLACE OF DEATH

County Saline Registration District No. 796
Township Marshall Primary Registration District No. 3038
City Marshall No. _____ St. _____ Ward _____

File No. _____
Registered No. 141

2. FULL NAME

Mazy Alice White
(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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 18 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>56</u>	<u>5</u>	<u>5</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Charley Wright

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

12. MAIDEN NAME OF MOTHER Nancy Chase

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

14. INFORMANT Nancy Wright
(Address)

15. FILED 9-13 1931 Mrs. John H. McQuinn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 - 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1931, to Sept 8, 1931, and that I last saw her alive on Sept 8, 1931, and that death occurred, on the date stated above, at 11:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

uterine tumor, fibroid
excessive pressure upon
and heart embolism
about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) no (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

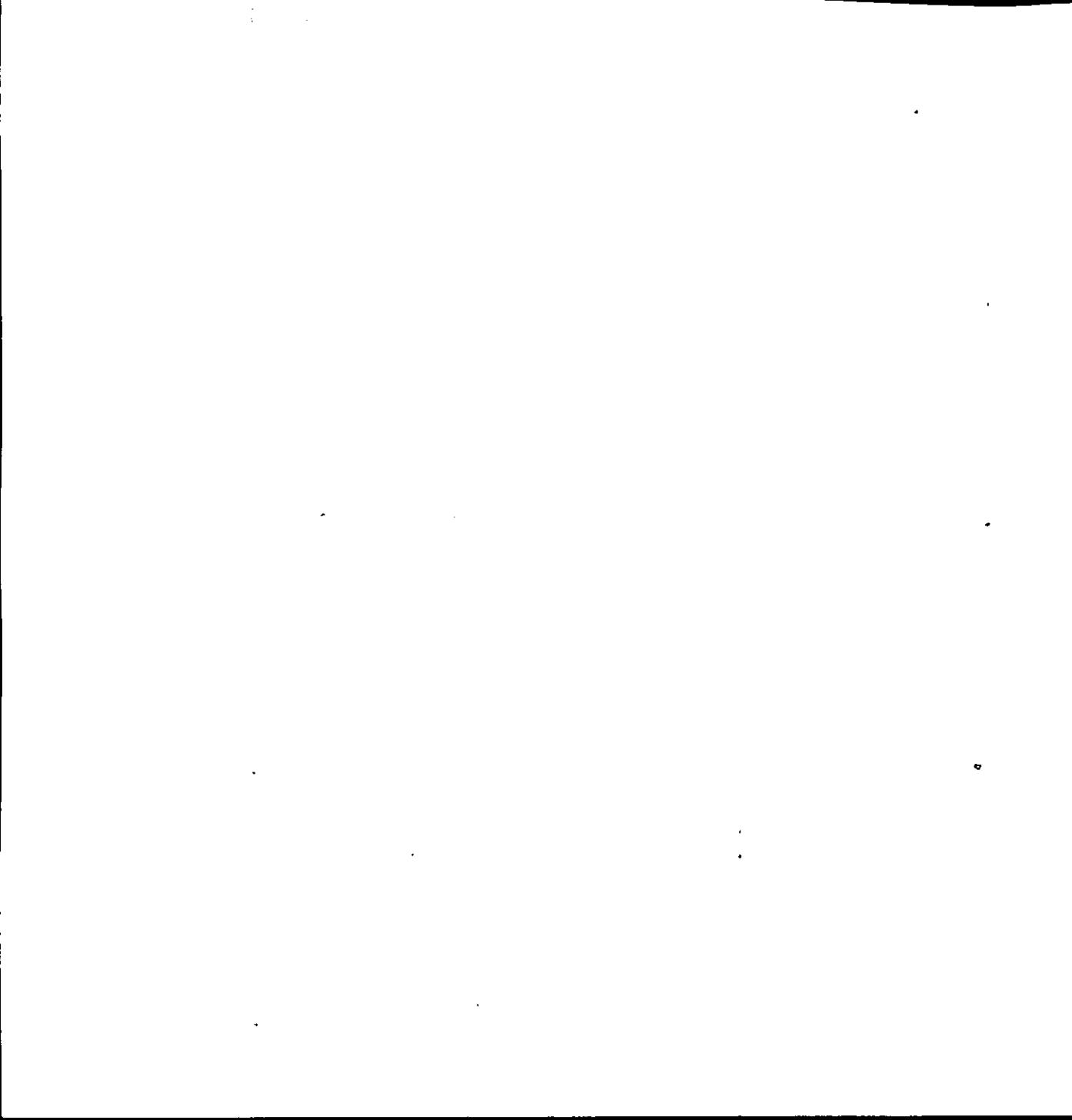
(Signed) R. W. Stouffer, M. D.

9/10 1931 (Address) Norton 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 Norton Cem DATE OF BURIAL Sept 11 1931

20. UNDERTAKER Ferguson Williams ADDRESS Marshall



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline
Township
City Marshall Mo.

Registration District No. 796
Primary Registration District No. 3038

File No. _____
Registered No. 141
St. _____ Ward)

2. FULL NAME

Mary Alice White
(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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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.

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) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED 9-13 1931 Mrs. John H. McQueen Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Uterine tumor fibroid
excessive pressure
symptoms and heart
trouble
Malignant
Other contributory causes of importance: _____

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) _____, M. D.
(Address) _____

SUPPLEMENTARY

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

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