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

Do not use this space.

34938

1. PLACE OF DEATH
County Linn Co. Registration District No. 496 File No.
Township Brookfield Primary Registration District No. 3025 Registered No. 70
City Brookfield (No. 506 West Ave. St. 2nd Ward)

2. FULL NAME Mabel Grace Bevier
(a) Residence, No. St. Catherine Mo. 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 White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF H. J. Bevier

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 20-1893

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
38	2	3	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife
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 15

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair County Mo.

FATHER
13. NAME Albert Wallace
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nova Scotia

MOTHER
15. MAIDEN NAME Anabel Schrader
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) H. J. Bevier St. Catherine Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bear Branch DATE 10/25 1931

19. UNDERTAKER (ADDRESS) Hunter & Rollins Brookfield Mo.

20. FILED 10-23 1931 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23, 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1931, to Oct 23, 1931
I last saw her alive on Oct 23, 1931. Death is said to have occurred on the date stated above, at 9:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Fibromyoma of uterus	1928
" 54B	
139C	

Other contributory causes of importance:
Surgical Shock — Oct 21-31

Name of operation Hysterectomy Date of Oct 21-31
What test confirmed diagnosis? Clinical Was there an autopsy? No

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) Jane Evans, M. D.
(Address) Brookfield Mo

Was this Fibromyoma malignant?

I consulted Dr. Evans and he states that the Growth was non malignant.

E E Jenkins M.D.
Reg.

1931
S-34938

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 Linn — Registration District No. 496 — File No.

Township — Primary Registration District No. 3025 — Registered No. 70

City Brookfield (No. ..... St. ..... Ward)

2. FULL NAME Mabel Grace Bevier

(a) Residence, No. ..... St., ... Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	W	M

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.

OCCUPATION

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)

FATHER

13. NAME

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

MOTHER

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 ..... 19 ..... *Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23, 1931

22. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., 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:

	Date of onset
Fibromyoma of Uterus	

Other contributory causes of importance: Surgical Shock

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

54B

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE ... RESCRIBED BY LAW

G-379 08