

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

Do not use this space.

35464

File No. 401
Registered No. 23
City _____ St. _____ Ward _____

1. PLACE OF DEATH

County Repley
Township Thomas
City _____ No. _____

Registration District No. 751
Primary Registration District No. 5990

2. FULL NAME

Jona Spell
(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 white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. E. Spell
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16. 1876
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 0 7

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

Sandburn Ind.
(STATE OR COUNTRY)

10. NAME OF FATHER

R. H. Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Sandburn Ind.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mayville Mc Kennan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

unknown Ind.
(STATE OR COUNTRY)

14.

INFORMANT J. E. Spell
(Address) Acorn mo

15.

FILED 10/30 1931 Stewhart REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1931 to Oct 23 1931
that I last saw her alive on Oct 22 1931 and that death occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic nephritis
131
126
135 B (duration) 3 (yr) 7 mos. 0 ds.
CONTRIBUTORY cholarc optitis, cholelithiasis
(SECONDARY) (duration) 2 (yr) 0 mos. 0 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) Stewhart _____ M. D.
10/24 (Address) Acorn 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

New Hope Cera 1931

20. UNDERTAKER

Gish Undert. Co Wagon Mo

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.

