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

37140

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.

JAN 20 1932

1. PLACE OF DEATH
County: Clark — Registration District No.: 191 — File No.:
Township: Folker — Primary Registration District No.: 5272 — Registered No.: 14
City: (No. St. Ward)

2. FULL NAME: Effie Bell McIntosh
(a) Residence. No. (Usual place of abode) St., Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 9 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: Arch B. McIntosh

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 22, 1894

7. AGE: Years 37 | Months 9 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Homemaker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Van Buren Co.
(STATE OR COUNTRY): Iowa

PARENTS
10. NAME OF FATHER: Benjamin Winters
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Iowa
12. MAIDEN NAME OF MOTHER: Elmira Snelling
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Iowa

14. INFORMANT: Mr. Arch B. McIntosh
(Address): Mt. Sterling Ia.

15. FILED 12-1-, 1931 R. G. Callihan, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 25 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1931, to Nov. 25, 1931, that I last saw her alive on Nov. 24, 1931, and that death occurred, on the date stated above, at 12-30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
(duration) yrs. mos. 16 ds.
CONTRIBUTORY (SECONDARY): Abortion at two months
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. W. Webb, M. D.
, 19 (Address) Bonnaparte, Ia.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Center Chapel Cem. — DATE OF BURIAL: Nov. 27 1931
20. UNDERTAKER: H. A. Burnett — ADDRESS: Keosauqua

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (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 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. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

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

PARENTS

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 12-1, 1931 R. G. Callihan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,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:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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