

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

Do not use this space.

41225

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Troy Primary Registration District No. _____
City Wacoas City No. Gen. Hosp #2 St. _____ Ward _____

File No. 5217
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 621 Charlotte St. Ward. 1
(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 <u>Female</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Unknown</u>		
7. AGE	YEARS	MONTHS
<u>60</u>		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation.
<u>none</u>		
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)		

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-29, 1934

22. I HEREBY CERTIFY, That I attended deceased from 12-16 - 1931, to 12-29, 1934
I last saw her alive on 12-29, 1931 Death is said to have occurred on the date stated above, at 10 P. m.
The principal cause of death and related causes of importance were as follows:
(Apoplexy) (Hemiplegia) Date of onset _____
fractured wrist
Acid fall at store 12/16/34
12/17/34
Other contributory causes of importance:
Pedunculosis _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Missouri</u>
13. NAME	<u>Unknown</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Unknown</u>
15. MAIDEN NAME	<u>Unknown</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Unknown</u>
17. INFORMANT (ADDRESS)	<u>Desk General Hosp #2</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE	<u>Leeds m</u> DATE <u>1-26-1935</u>
19. UNDERTAKER (ADDRESS)	<u>J. B. Moore 1820 E 18th St</u>
20. FILED	<u>12/31 1934 M. M. Conner Registrar</u>

Name of operation _____ Date of _____
What test confirmed diagnosis? Lab. 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? _____
If so, specify _____
(Signed) D. M. Miller M. D.
Supt. Gen. Hosp #2 (Address)

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.

