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.

FEB 23 1932

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1940

1. PLACE OF DEATH

74 County Nodaway — Registration District No. 629 — File No. 321

Township Jackson — Primary Registration District No. 5831 — Registered No. 1

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

2. FULL NAME Mamie O. McLaughlin

(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)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William T. MacLaughlin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-30-1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	53	2	19	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) 235

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Near Sweet Home
(STATE OR COUNTRY) Nod Co Mo. 1

PARENTS

10. NAME OF FATHER John Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) 2
(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Hannah Jane Barton

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

14. INFORMANT Myrtle Crawford
(Address) Ravenwood Mo

15. FILED 1/21 1932 S. P. Ross — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 19 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1932, to Jan 19th, 1932 that I last saw her alive on Jan 18th, 1932, and that death occurred, on the date stated above, at 9-30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 108

108 82 B

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Cerebral Thrombosis

(duration) ..... yrs. ..... mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? (1)

0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L E Dean, M. D

, 19 (Address) Maryville 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	DATE OF BURIAL
Oak Lawn Cemetery Ravenwood Mo	Jan 21 1932
20. UNDERTAKER	**ADDRESS**
Ross & Long	Ravenwood Mo

MISSOURI STATE BOARD OF H...

BUREAU OF VITAL STATISTICS

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....., 19..... .....
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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.