

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

3812

85

1. PLACE OF DEATH

County Boscawen Registration District No. 1001
 Townshlp St. Joseph Primary Registration District No. 1001
 City St. Joseph (No. State Hospital #2)

File No. 164
 Registered No. 164 St. _____ Ward _____

2. FULL NAME Fannie Jones

(a) Residence, No. St. Joseph Mo. St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. 5 mos. 2 ds. Plus How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____
 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1862</u>		
7. AGE <u>70</u>	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Nashville
 (STATE OR COUNTRY) Tennessee 2

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown 31
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Nov. Proctor
 (Address) State Hosp #2 St. Joseph Mo

15. FILED 278 1932 John L. Bender 2.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 18 1932
 17. I HEREBY CERTIFY, That I attended deceased from August 20 1931, to February 18 1932, that I last saw h. a. alive on February 15 1932, and that death occurred, on the date stated above, at 7:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchitis Pneumonia
Chronic Myocarditis
 (SECONDARY)
 (duration) yrs. _____ mos. 20 ds. _____

18. WHERE WAS DISEASE CONTRIBUTED
 IF NOT AT PLACE OF DEATH at place of Death
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
 (Signed) George W. Forman M. D.

Ac 18 . 1932 (Address) State Hosp #2 St. Joseph
 *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 Mt. Mora DATE OF BURIAL Febr. 20 1932
 20. UNDERTAKER Fleeman Funeral Home ADDRESS 1946 Coltham

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.

APR 21 1932

