

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

Do not use this space.

1. PLACE OF DEATH

33 County Dent
Township Gladden
City..... (No.....)..... St..... Ward.....

Registration District No. 997
Primary Registration District No. 6238

File No. 4220
Registered No. 2
St..... Ward.....

2. FULL NAME

Ruby Thelma Golden

(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) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF -----

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 6 1914

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
17 3 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Dent Co
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER William Golden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dent Co
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Lula Kell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dent Co
(STATE OR COUNTRY) Mo

14. INFORMANT William Golden
(Address) Jadwin Co

15. FILED 3/10 19 32 F. M. Jadwin
REGISTRAR F. M. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1932

17. I HEREBY CERTIFY, That I attended deceased from 7:00 P to 7:32 19 32 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 6:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis
2-3 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) 2-3 (duration)..... yrs..... mos..... ds.

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

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. J. Gibson M. D.
2/6 19 32 (Address) Salem 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 Cem DATE OF BURIAL Feb 9 1932

20. UNDERTAKER Carl K Spencer ADDRESS Salem 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.

FEB 28 1932

