

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

Do not use this space.
35183

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 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) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis M. Mayberry		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 25-1857		
7. AGE	YEARS 74	MONTHS 10
	DAYS 20	IF LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housework
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. dry
	10. Date deceased last worked at this occupation (month and year) Kentucky 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Kentucky 2

13. NAME
no information

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
deceased at 36

15. MAIDEN NAME
two yrs of age

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
no info

17. INFORMANT (ADDRESS)
Mrs. O. W. Calvin
324 Chestnut

18. BURIAL, CREMATION, OR REMOVAL (PLACE) (DATE)
Buried No. Nov 17 32

19. UNDERTAKER (ADDRESS)
Hansen & James
Jefferson City

20. FILED 11/18/32 Dr. Besford Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15 1932

22. I HEREBY CERTIFY, That I attended deceased from Oct 15 1932 to Nov 15 1932
I last saw her alive on Nov 15 1932 Death is said to have occurred on the date stated above, at 6:55 AM
The principal cause of death and related causes of importance were as follows:

Terminal Pneumonia
No
3 112 J. A. Hill
Other contributory causes of importance:
Senile cerebral atrophy resulting in partial paralysis of cerebral gas ducts

Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical 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? no
If so, specify _____
(Signed) Jas. A. Hill, M. D.
(Address) Jefferson City, Mo

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.

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989
9 1932

