

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

Do not use this space.

35724

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Ray Primary Registration District No. _____
 City Ray (No. Research Hospital) St. _____ Ward _____
 Registered No. 4228

2. FULL NAME

(a) Residence, No. 343 North Lawrence (b) _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>about</u>	<u>57</u>			

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 235

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mal

13. NAME Thomas Spencer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delaware

15. MAIDEN NAME Bridget M. Keenan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) C. Massey

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 11/12/32

19. UNDERTAKER (ADDRESS) 7. D. ...

20. FILED Nov 11, 1932 Registrar M. ...

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 9, 1932

22. I HEREBY CERTIFY, That I attended deceased from 1 Sept to Nov 9 1932
 I last saw her alive on Nov 8 1932 Death is said to have occurred on the date stated above, at 1:50 PM

The principal cause of death and related causes of importance were as follows:

Myocardial Infarct
9310
 Other contributory causes of importance:
Defective teeth: Root abscesses
(teeth): chronic arthritis

Name of operation none Date of _____
 What test confirmed diagnosis? biopsy 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? _____
 If so, specify _____
 (Signed) Frederic E. Murphy, M. D.
 (Address) Professional Bldg, 730

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.

