

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

Do not use this space.

36302

1. PLACE OF DEATH

County Linn Registration District No. 491
 Township _____ Primary Registration District No. 4298
 City Jay (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 74

2. FULL NAME

Anna Beth Montgomery
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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 Luther Montgomery

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22 - 1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
49 10 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer). 235
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hawk Point (STATE OR COUNTRY) Mo

10. NAME OF FATHER Peter Cropper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hawk Point (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Anna E. Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bowling Green (STATE OR COUNTRY) Ky

14. INFORMANT Luther Montgomery (Address) Jay - Mo

15. FILED 11-11-37 W.P. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1937

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1937, to Nov 10, 1937 that I last saw him alive on Nov 10, 1937 and that death occurred, on the date stated above, at 5 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Failure caused from acute nephritis
130

(duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 130 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Symptoms
 (Signed) W.P. Smith, 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 Jay Cemetery DATE OF BURIAL Nov 13 1937

20. UNDERTAKER W.P. Smith ADDRESS Jay 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.

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