

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

Do not use this space.

36743

1. PLACE OF DEATH *Pauls*  
 County *Franklin Mo* Registration District No. *70*  
 Township *Manor* Primary Registration District No. *6930*  
 City *Septer Pauls Mo* (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. *02*  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Alpha May Conitt*  
 (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)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Clara Becht*

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*59*      *5*      *13*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *housewife 235*  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *house keeping*  
 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) *Coalfield Mo*

13. NAME *Chas C Conitt*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison Mo*

15. MAIDEN NAME *Elizabeth Anderson*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Croft Mo*

17. INFORMANT *Elizabeth Conitt*  
 (ADDRESS) *Pauls Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Pauls Mo* DATE *Nov 20, 1932*

19. UNDERTAKER *White Bros. Pauls Mo*  
 (ADDRESS) \_\_\_\_\_

20. FILED *11-20-1932* *J. J. [Signature]*  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 19th, 1932*

22. I HEREBY CERTIFY, That I attended deceased from *7-1*, 19*32* to *11-19*, 19*32*

I last saw her alive on *11-17*, 19*32* Death is said to have occurred on the date stated above, at *1 a* m.

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

*Carcinoma of Esophagus* Date of onset *6-1-32*  
*46*      *46*

Other contributory causes of importance: *none* *(D)*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) *Kyle McCreaw*, M. D.  
 (Address) *Pauls Mo*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAN

84

level

tax

10

10

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jackson  
Township Marion  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 901  
Primary Registration District No. 5930

File No. \_\_\_\_\_  
Registered No. 52  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED SM (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 6 - 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
59 5 19

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

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

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) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 11-20-1932 J. P. Roberts Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/19/32

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

**SUPPLEMENTARY**

REG. S. SHALL NOT RECEIVE A FEE FOR CERTIFICATION. L. THEY ARE COMPLETE AS PRESCRIBED BY. Exact statement of OCCUPATION is very -

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