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.

JAN 23 1933

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

Do not use this space.

1. PLACE OF DEATH

47 County Irron — Registration District No. 390 — File No. 39485

Township [illegible] — Primary Registration District No. 5545 — Registered No. 21

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Matilda Douglas.

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
female	white	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 15 1759

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73	9	10	

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

9. BIRTHPLACE (CITY OR TOWN) Glover
(STATE OR COUNTRY) Mo. 1

PARENTS

10. NAME OF FATHER Wm Swingeen.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) 2
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Sallie Hoff
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo. 1

14. INFORMANT J Huff
(Address) Sabula Mo

15. FILED Jan 5, 1932 B C Gunter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 1932

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1932 to Dec 25, 1932 that I last saw her alive on Dec 25, 1932, and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Flu.

11B

162

11B

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED (1)

IF NOT AT PLACE OF DEATH x

DID AN OPERATION PRECEDE DEATH? no DATE OF x

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? x

(Signed) F F Farr, M. D.

, 19 (Address) Des Arc 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	DATE OF BURIAL
Glover. Mo	Dec 26 1932
20. UNDERTAKER	ADDRESS
none.	—