

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.

JUL 20 1933

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

108 <sup>X</sup>/<sub>G</sub>

## 1. PLACE OF DEATH

5 County Barry  
 Township Leisure  
 City Leisure (No. \_\_\_\_\_)

Registration District No. 29  
 Primary Registration District No. 5048

File No. \_\_\_\_\_  
 Registered No. 6  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

Susan R. Alsbrooks  
 (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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF R. R. Alsbrooks  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 15 - 1852  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
80 3 11

8. Trade, profession, or particular kind of work done, as planner, sawyer, bookkeeper, etc. Housewife  
 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) Mo

FATHER 13. NAME J. W. Zinn  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Nancy Smith  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Anna Turner  
 (ADDRESS) 621 W. Central Parkway

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Leisure DATE 1/27 1933

19. UNDERTAKER King Funeral Home  
 (ADDRESS) Leisure

20. FILED July 1, 1933 Mrs H. R. Williams  
Dpt. Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26 1933

22. I HEREBY CERTIFY, That I attended deceased from 1-23 1933 to 1-26 1933.

I last saw him alive on 1-25 1933. Death is said to have occurred on the date stated above, at 7:15 A. m.

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

Coronary Thrombosis Date of onset \_\_\_\_\_

95A 95A

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) J. R. Dr. Smith M. D.

(Address) Crane 2600

2712