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

Do not use this space.

5545

MAR 28 1933

1. PLACE OF DEATH
County Howell — Registration District No. 382 — File No. 5547
Township — Primary Registration District No. 4227 — Registered No.
City West Plains, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Mrs S. M. Oaks

(a) Residence, No. ..... St., ... Ward. (If nonresident, give city or town and State)
(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 Fe
4. COLOR OR RACE Wht
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 21 1865

7. AGE Years 67 Months 9 Days 27 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, 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) Illinois

FATHER
13. NAME Joseph Hart
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Kno

MOTHER
15. MAIDEN NAME Caroline Walker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mary Co, Mo

17. INFORMANT (ADDRESS) Mrs Daugherty West Plains Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Dixon, Mo, DATE 2-18-1933

19. UNDERTAKER (ADDRESS) McFarlands West Plains Mo

20. FILED 2-18-1933 O. P. A. Heinrich Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb-18, 1933

22. I HEREBY CERTIFY, That I attended deceased from Feby-9-1933 to Feby 18-1933
I last saw her alive on Feby-18-1933 Death is said to have occurred on the date stated above, at 7 40 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	

Other contributory causes of importance: Fractured Right Femur

Name of operation None 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) R E Hogan, M. D.
(Address) West Plains Mo

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.

NOT FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

Do not use this space

File No. 41

Registered No.

1. PLACE OF DEATH

County..... Registration District No.....

Township..... Primary Registration District No.....

City..... (No..... , ... St. .....

2. FULL NAME.....

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

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mo

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.

OCCUPATION

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)

FATHER

13. NAME

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

MOTHER

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..... 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended dec

....., 19....., to.....

I last saw h..... alive on....., 19..... I

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

The principal cause of death and related causes of importance wer

.....

.....

.....

.....

.....

Other contributory causes of importance:

.....

.....

.....

Name of operation..... Date of....

What test confirmed diagnosis?..... Was there an auto

23. If death was due to external causes (violence), fill in also the f

Accident, suicide, or homicide?..... Date of injury.....

Where did injury occur?.....
(Specify city or town, county, and

Specify whether injury occurred in industry, in home, or in public p

.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of dece

If so, specify.....

(Signed).....

(Address).....

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: Macon — Registration District No. 384 — File No. 21

Township: — Primary Registration District No. 4227 — Registered No.

City: West Plains (No. ..., ... St. ..... Ward)

2. FULL NAME Mrs. S. M. Dakes

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 21 - 1865

7. AGE: Years 67 — Months 9 — Days 27 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
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 2-18, 1923 O. A. Heinrich, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 18, 1923

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..
I last saw h... 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
Cardiac Myocarditis	

Other contributory causes of importance:
Fractured right femur
Caused by fall on ice

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

F... — 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

5-5545