

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

Do not use this space.

6297

1. PLACE OF DEATH

54 County Seymour
Township Wagon Wheel
City Wagon Wheel (No. _____) Ward _____

Registration District No. 457
Primary Registration District No. 6210

File No. _____
Registered No. 10
St. _____ Ward _____

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

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

Sept. 2, 1929

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>3</u>	<u>5</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Near Higginsville

(STATE OR COUNTRY) Mo

10. NAME OF FATHER

Wm J Newland

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Near H-ville

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Lorena Parker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Fort Wayne, Indiana

(STATE OR COUNTRY)

14.

INFORMANT

Mrs W J Newland
(Address) Higginsville Mo

15.

FILED

9-19-33 Berdinand Shryman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb. 19 - 1933

17.

I HEREBY CERTIFY, That I attended deceased from 2-15-33

....., 1933, to 2-19-, 1933
that I last saw her alive on 2-18-, 1933, and that death occurred, on the date stated above, at 12:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute nephritis
Bacteremia
Toxemia (streptococcal)
(duration) yrs. mos. 10 da.

CONTRIBUTORY (SECONDARY)

pneumonia
(duration) yrs. mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... ✓

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS History & physical exam

(Signed) R. F. McMissary, M. D.

2-19, 1933 (Address) Wagon Wheel, 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

Oak Grove

DATE OF BURIAL

2/20/1933

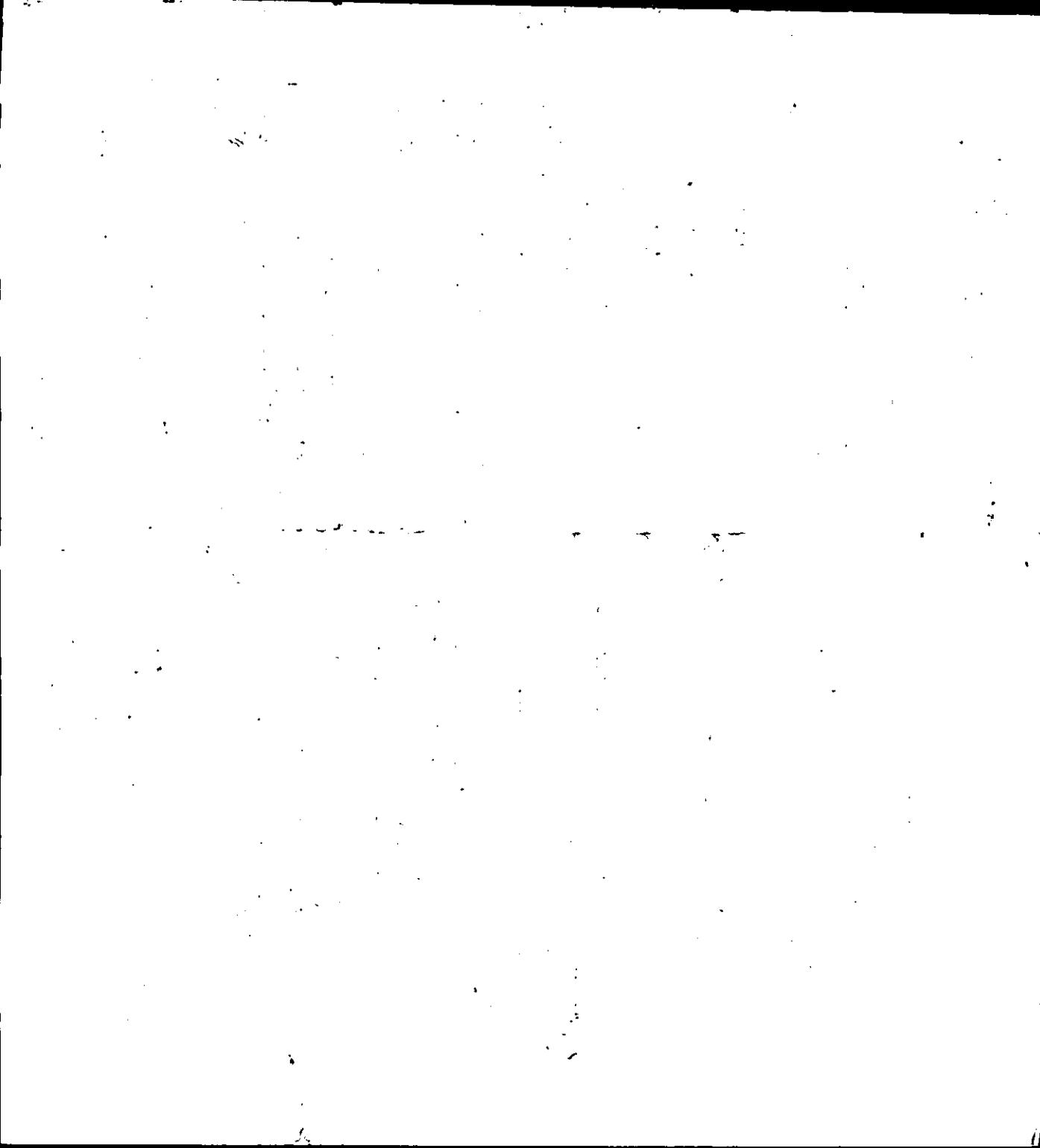
20. UNDERTAKER

A. N. Hadler

ADDRESS

H-ville 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.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lafayette
Township St. Stephen
City (No.)

Registration District No. 457
Primary Registration District No. 5621st

File No.
Registered No. 10
St. Ward)

2. FULL NAME Edna Mae Neuland

(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) S.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 2 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 5 17

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)

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 Feb 19 19 27 Ferdinand Shyman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 19, 1933

22. I HEREBY CERTIFY, That I attended deceased from

to, 19

I last saw h. alive on, 19

Death is said to have occurred on the day stated above, at

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

Acute nephritis
Bacterial
transmitted

Date of onset

Other contributory causes of importance:

Chronic pneumonia

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

107A

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