

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

Do not use this space.

**1. PLACE OF DEATH**

81 County Shelby  
Township Dillon  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 118  
Primary Registration District No. 118

File No. 6783  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Ida M. Quick  
(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 10 yrs. 0 mos. 0 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) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-12-1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
84 8 7

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife  
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) 1-10-33 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mitchell Co Iowa

MOTHER 13. NAME Lyman Dexter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Aline Lamphere

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Arlene Knight (ADDRESS) Conway mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Home DATE Feb 21 1933

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

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Registrar \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-19 1933

22. I HEREBY CERTIFY, That I attended deceased from Feb 1 - 1933, to Feb 16, 1933

I last saw him alive on Feb 19, 1933. Death is said to have occurred on the date stated above, at 11:30 p.m.

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

Acute Senilis  
151  
192A / 131  
Other contributory causes of importance:  
Chronic Intestinal Nephritis

Date of onset  
1930

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? no

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) William H. ..., M. D.  
(Address) St. James, 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 Phillips Registration District No. 678  
Township Hickman Primary Registration District No. 5902  
City (No. ) St. Ward

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>W</u> (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June - 12 - 1848</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>84</u>	<u>8</u>	<u>7</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	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) <u>Jan 12 - 1933</u>			
11. Total time (years) spent in this occupation				
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mitchell, Missouri</u>				
MOTHER	13. NAME <u>Theresa Marie</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
	15. MAIDEN NAME <u>Oliver</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>				
17. INFORMANT <u>John G. Smith</u>				
(ADDRESS) <u>Phillips, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE <u>Wasson</u> DATE <u>Feb 21</u> 19 <u>33</u>				
19. UNDERTAKER <u>H. E. Licklider</u>				
(ADDRESS) _____				
20. FILED _____ 19. _____ Registrar <u>H. H. Walters</u>				

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

22. I HEREBY CERTIFY, That I attended deceased from Feb 1 1933, to Feb 16 1933

I last saw h. alive on Feb 19 1933 Death is said to have occurred on the date stated above, at 11:45 P.M.

The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Chronic interstitial nephritis

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

What test confirmed diagnosis? Clinical 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) John G. Smith, M. D.  
(Address) Phillips, Mo.

**SUPPLEMENTARY**

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

5-6793