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

Do not use this space.

8195

1. PLACE OF DEATH
County: Shelby — Registration District No.: 831
Township: Black Creek — Primary Registration District No.: 6092
City ..... (No. ....., ... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME: Margaret Catherine Vannoy

(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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar 9 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73	11	12	

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

9. BIRTHPLACE (CITY OR TOWN): .....
(STATE OR COUNTRY): Shelby Co. Mo.

PARENTS

10. NAME OF FATHER: Stevenson Collins

11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ky

12. MAIDEN NAME OF MOTHER: Sarah Courtord

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ky

14. INFORMANT: Milton Vannoy
(Address): Shelbyville, Mo

15. FILED Feb 23 1933 Emmrette A. Howerton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 22 1933

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1932 to Sept 22, 1933 that I last saw her alive on Feb 22, 1933, and that death occurred, on the date stated above, at 1:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

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? Clinical symptoms
(Signed) W. D. Lillie, M. D
, 19 (Address) Shelbyville 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
Oak Dale Cemetery	Feb 23 1933
20. UNDERTAKER	**ADDRESS**
J. W. Thompson & Son	Shelbyville

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD