

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

Do not use this space.

96.97
1301

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township New Primary Registration District No. _____
City N. C. Mo (No. 806 Cleveland) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Mary Huskinson
(a) Residence, No. 806 Cleveland 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. A. Huskinson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-5-1863
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 4 17
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
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) Arkansas
13. NAME Hindspathe
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME No Record
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Frank M. Leale (ADDRESS) 806 Cleveland
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Wash DATE 3/20/33
19. UNDERTAKER Mrs. C. L. Forester (ADDRESS) 918 Franklin Ave
20. FILED 3-18 1933 M. M. C. Powell Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/17/33 1933
22. I Derek Byrd CERTIFY, That I attended deceased from _____ to _____, 19____.
I last saw him 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:
Chronic ulcerative pulmonary tuberculosis
Date of onset _____

Other contributory causes of importance:
230 23

Name of operation _____ Date of _____
What test confirmed diagnosis Autopsy Was there an autopsy yes

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) [Signature] _____, M. D.
(Address) [Address]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

