

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.

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

Do not use this space.

28519

1. PLACE OF DEATH

County Scott
Township Sylvania
City — (No. —)

Registration District No. 520
Primary Registration District No. 6069

File No. —
Registered No. —
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. 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/5/88

7. AGE YEARS MONTHS DAYS If LESS than 1 day, X hrs. or X min.
44 8 13 X

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)

10. NAME OF FATHER Joe Watson

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

12. MAIDEN NAME OF MOTHER Janie Aldridge

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

14. INFORMANT Shelby Ames
(Address) Oran Mo

15. FILED 9/9/33 W. Slickman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/18 1933

17. I HEREBY CERTIFY, That I attended deceased from on
8/18, 1933, to —, 19—
that I last saw her alive on 8/18, 1933, and that
death occurred, on the date stated above, at 5:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Painful Green Poisoning
(Suicidal probably)
(mental condition bad)

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) J. A. Cline, M. D.

, 19 33 (Address) Oran 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

Franklin County 8/20 1933

20. UNDERTAKER

ADDRESS

Alois Anger Leopold Mo

