OCT 20 1933

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

Do not use this space. 30514

1. PLACE OF DEATH
County Pettis
Township La Monte
City La Monte
Registration District No. 667
Primary Registration District No. 4400
File No.
Registered No. 12
(No. , St. Ward)

2. FULL NAME Rebecca Burrell

(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

[redacted]th of residence in city or town where death occurred 50 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 B
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan about 1850

7. AGE YEARS Almost 83. MONTHS DAYS If LESS than 1 day, hrs. or min.

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) Pettis Co
[redacted] (STATE OR COUNTRY) Mo.

FATHER
13. NAME James Black
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott Kron

MOTHER
15. MAIDEN NAME Lucy Joplin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott Kron

17. INFORMANT (ADDRESS) Clarence Davis La Monte Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE Sep = 24 1933

19. UNDERTAKER (ADDRESS) B. F. Parker La Monte Mo

[illegible]ED Sep. 23 1933 B. F. Parker, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9 = 21 1933

22. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1933, to Sept 21, 1933
I last saw her alive on Sept 21, 1933. Death is said to have occurred on the date stated above, at 1 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	9-5-33
87 A	

Other contributory causes of importance:

Name of operation ✓ Date of ✓
What test confirmed diagnosis? Usual 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) W. E. Walker, M. D.
(Address) La Monte Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

Do not use this space.

File No.....

Registered No.....

1. PLACE OF DEATH

County..... Registration District No.....

Township..... Primary Registration District No.....

City..... (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

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

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

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

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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

MOTHER

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....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h..... 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:

	Date of onset

Other contributory causes of importance:

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).....