

MAR 24 1934

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

Do not use this space.

4308

1. PLACE OF DEATH

County Clay
Township Gallatin
City Arundale, Mo.

Registration District No. 197
Primary Registration District No. 5276

File No. 4308
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Arundale, Mo. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar-7-1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 11 13 _____

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. child

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) Billings, Okla.

13. NAME Wayne H. Mc Coy

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

15. MAIDEN NAME Nellie Abbott

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.

17. INFORMANT (ADDRESS) Wayne H. Mc Coy
Arundale, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Billings, Okla. DATE Feb 21, 1934

19. UNDERTAKER (ADDRESS) Morton + Co.
W. K. C. Mo.

20. FILED Feb 21, 1934 John S. Morton
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 20, 1934

22. I HEREBY CERTIFY, That I attended deceased from February 15, 1934, to February 20, 1934

I last saw h. or alive on February 20, 1934. 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:

Broncho-pneumonia Date of onset 2/15/34

Other contributory causes of importance: _____

Name of operation nonfatal Date of _____
What test confirmed diagnosis? Clement 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 _____

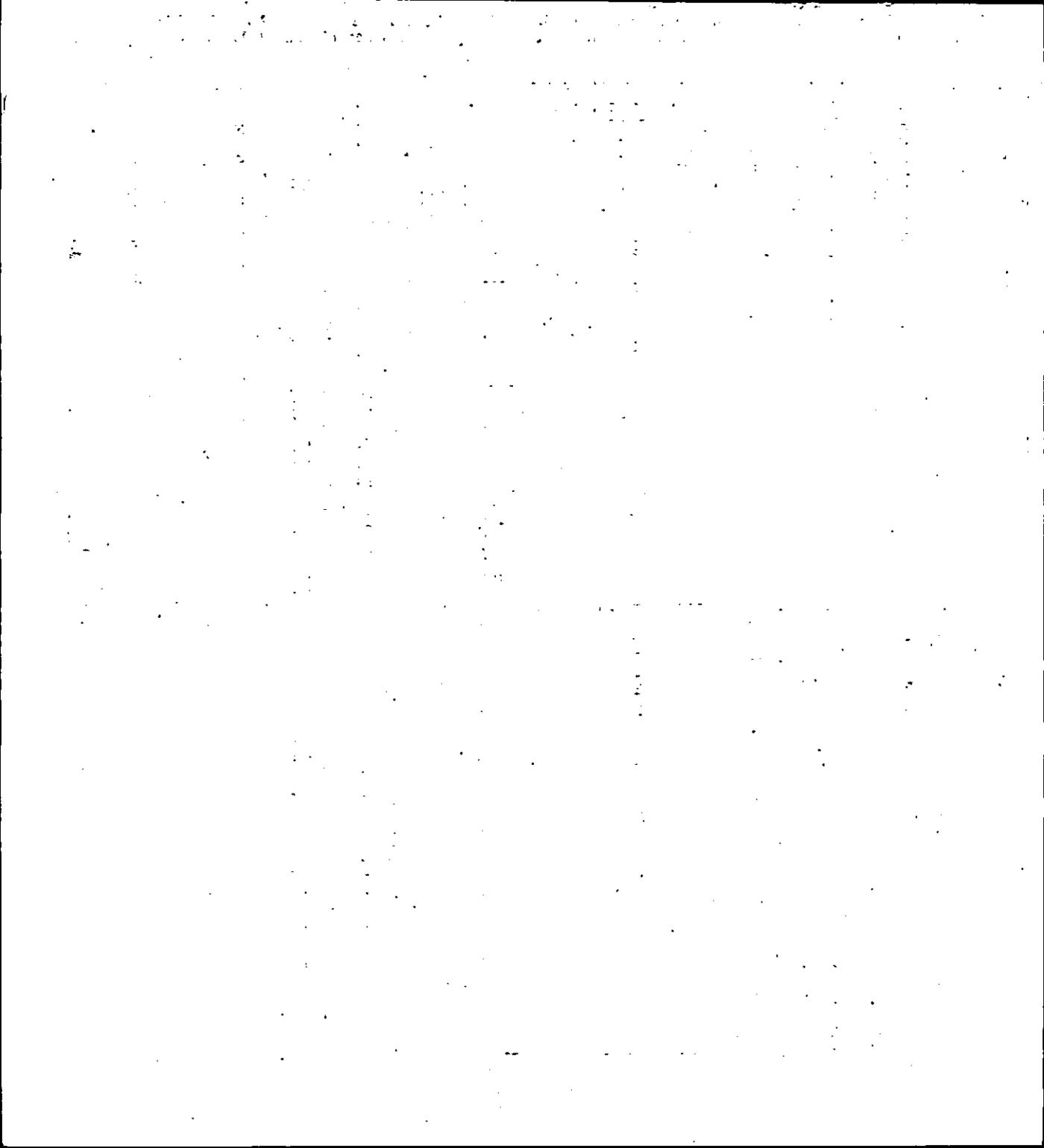
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Harry R. Staley M. D.
(Address) North Kansas City, 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.



#2 Clay

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 4308

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mary Beth Mc Coy
Who died at on Feb - 20 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, ~~married~~, ~~widowed~~ or ~~divorced~~: _____

Date of birth _____ Age: Years 9 Months 11 Days 13

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month 10 year 1934

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Bronchitis Pneumonia
No cough eaten other than pneumonia

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician Viola T. Meyer _____

Signature of Registrar _____ Date filed July 12 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 197

Very truly yours,

Primary Reg. Dist. No. 5276

E. T. McLaugh, M.D.
Special Agent.

5-4308

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