

MAY 25 1934

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County HentryRegistration District No. 310Township DarlingtonPrimary Registration District No. 641292City Darlington (No. 4131)File No. 4545-ARegistered No. 98

St. _____ Ward)

2. FULL NAME Alverda James

(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 widow

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

Albert James

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

69811

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Hentry Co. Mo.

10. NAME OF FATHER

Whitney Edwards

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Rachel Steves

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. -

INFORMANT

(Address)

Mrs. L. W. GroomDarlington

15. FILED

19

Matthie Llorid

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 22 1934

17.

I HEREBY CERTIFY, That I attended deceased from 1-25, 1934, to 2-22, 1934. that I last saw her alive on 2-13, 1934, and that death occurred, on the date stated above, at 9-45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
Ch. nephritis
exoph. gonorr.
(duration) 3 yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Ch. nephritis
exoph. gonorr.
(duration) 10 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? noWHAT TEST CONFIRMED DIAGNOSIS? Clin.

(Signed)

Frank H. Rose, M. D.2-23, 1934 (Address) Albany, 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

Rouse CemeteryFeb. 24 1934

20. UNDERTAKER

ADDRESS

A. J. BareAlbany

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.

