

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAY 25 1934

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

Do not use this space.

13049

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Joe, Mo. (No. General Hospital 3rd Ward) Registrar No. _____

2. FULL NAME

(a) Residence, No. Rose Daucus Ward. _____
(Usual place of abode) 423 Carfield
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Ray Daucus</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11-5-1894</u>		
7. AGE <u>39</u>	YEARS <u>5</u>	MONTHS <u>10</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Maid</u>		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>		
13. NAME <u>Unknown</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Record Clerk</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dallas Texas</u> DATE <u>4-23-34</u>		
19. UNDERTAKER (ADDRESS) <u>Watkins Bros Undt</u> <u>1729 Lyda</u>		
20. FILED <u>4-23-34</u> <u>3pm</u> <u>Coroner</u> <u>ason</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-20, 1934

22. I HEREBY CERTIFY, That I attended deceased from 4-1, 1934, to 4-20, 1934
I last saw her alive on 4-20, 1934 Death is said to have occurred on the date stated above, at 5:45 a.m.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
arteriosclerosis of the cerebral vessels
Other contributory causes of importance:
None

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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? No
If so, specify _____
(Signed) R. O. Turner M. D.
(Address) General Hosp #2

