

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County Macou
Township _____
City New Cambria (No. _____)

Registration District No. 534
Primary Registration District No. 4319

File No. 13529
Registered No. _____
St. _____ Ward _____

2. FULL NAME

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

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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18-1861

7. AGE YEARS 72 MONTHS 8 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.

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

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) Wales

13. NAME David Roberts

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

15. MAIDEN NAME Ellen Williams

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

17. INFORMANT Mrs Ellen Ann Jones (ADDRESS) New Cambria Mac

18. BURIAL, CREMATION, OR REMOVAL PLACE New Cambria DATE _____ 19 _____

19. UNDERTAKER J. B. Williams (ADDRESS) New Cambria Mac

20. FILED Apr-10 19 34 Alta M. West Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10, 1934

22. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Apr 10, 1934

I last saw her alive on Apr 9, 1934. Death is said to have occurred on the date stated above, at 2:30 a.m.

The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis

1170
1180
1180

Other contributory causes of importance:
Acute Indigestion

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 _____

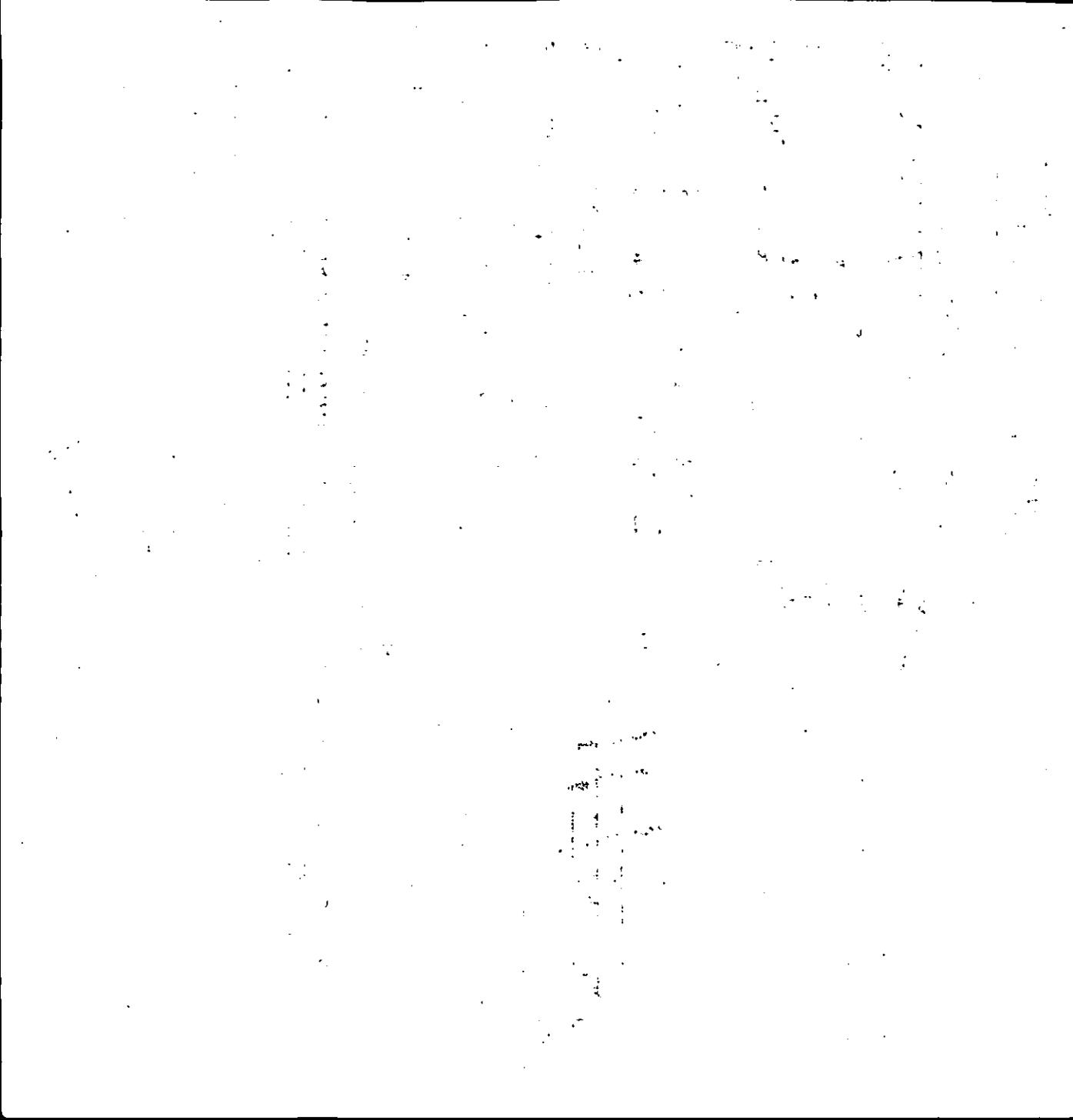
Where did injury occur? _____ (Specify city or town, county, and State)

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? No

If so, specify _____ (Signed) Dr. West, M. D.
(Address) New Cambria Mac



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1.3529

1. PLACE OF DEATH

County Mason
Township
City New Cambria (No.)

Registration District No. 534
Primary Registration District No. 4319

File No.
Registered No.
St. Ward)

2. FULL NAME

Lone Jones

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

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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 OK 10 1934 C. O. West Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 10 1934

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

6 Chronic Myocarditis

Other contributory cause of importance

Acute indigestion
going a long period
since then

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

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) B. B. Fret, M. D.

(Address) New Cambria

SUPPLEMENTARY

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S-13529