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

Do not use this space.

JUN 22 1934

1. PLACE OF DEATH
County: Lafayette
Township: Dover
City: Higginsville (No. ..... St. ..... Ward)
Registration District No. 460
Primary Registration District No. 5623
File No. 17267
Registered No. 28

2. FULL NAME: Mary Elizabeth McMahan
(a) Residence. No. Confederate Home St., ..... Ward. ..... (If nonresident give city or town and State)
(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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Fly W McMahan

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 5. 1854

7. AGE: Years 88 | Months 4 | Days 18 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): —
(STATE OR COUNTRY): —

PARENTS
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): —
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): —

14. INFORMANT: Roy Stone
(Address): Higginsville Mo

15. FILED: June 2 19 34 W. C. McC REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5/8 1934

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1934 to May 8, 1934 that I last saw her alive on May 8, 1934 and that death occurred, on the date stated above, at 12 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
10 Yr
10 Yr
(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) F. A. Howard, M. D
, 19 (Address) Higginsville 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: Confederate Home
DATE OF BURIAL: 5/10 1934

20. UNDERTAKER: A. H. Hoder Higginsville Mo
ADDRESS

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.