

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

Do not use this space.

24527
2125

1. PLACE OF DEATH

County Jackson
Township Man
City Kansas

Registration District No. 399
Primary Registration District No. 1009
(No. Mercy Hospital)

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

2. FULL NAME

(a) Residence, No. Peculiar mo 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— 7 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
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) Kingsville MO

13. NAME Joseph Hobbs

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kingsville MO

15. MAIDEN NAME Cora Apple

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Allen MO

17. INFORMANT (ADDRESS) Joseph Hobbs Kingsville MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Staff Spring cemetery Kingsville MO DATE July 16-34

19. UNDERTAKER (ADDRESS) Pasantonis Bros. MO

20. FILED July 15 1934 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 14 1934

22. I HEREBY CERTIFY that I attended deceased from _____, 19____
Staff Spring
I last saw him 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:
Bronchopneumonia
(Primary) (1079) Date of onset _____

Other contributory causes of importance: no

Name of operation _____ Date of operation _____
What test confirmed diagnosis? Autopsy 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 _____

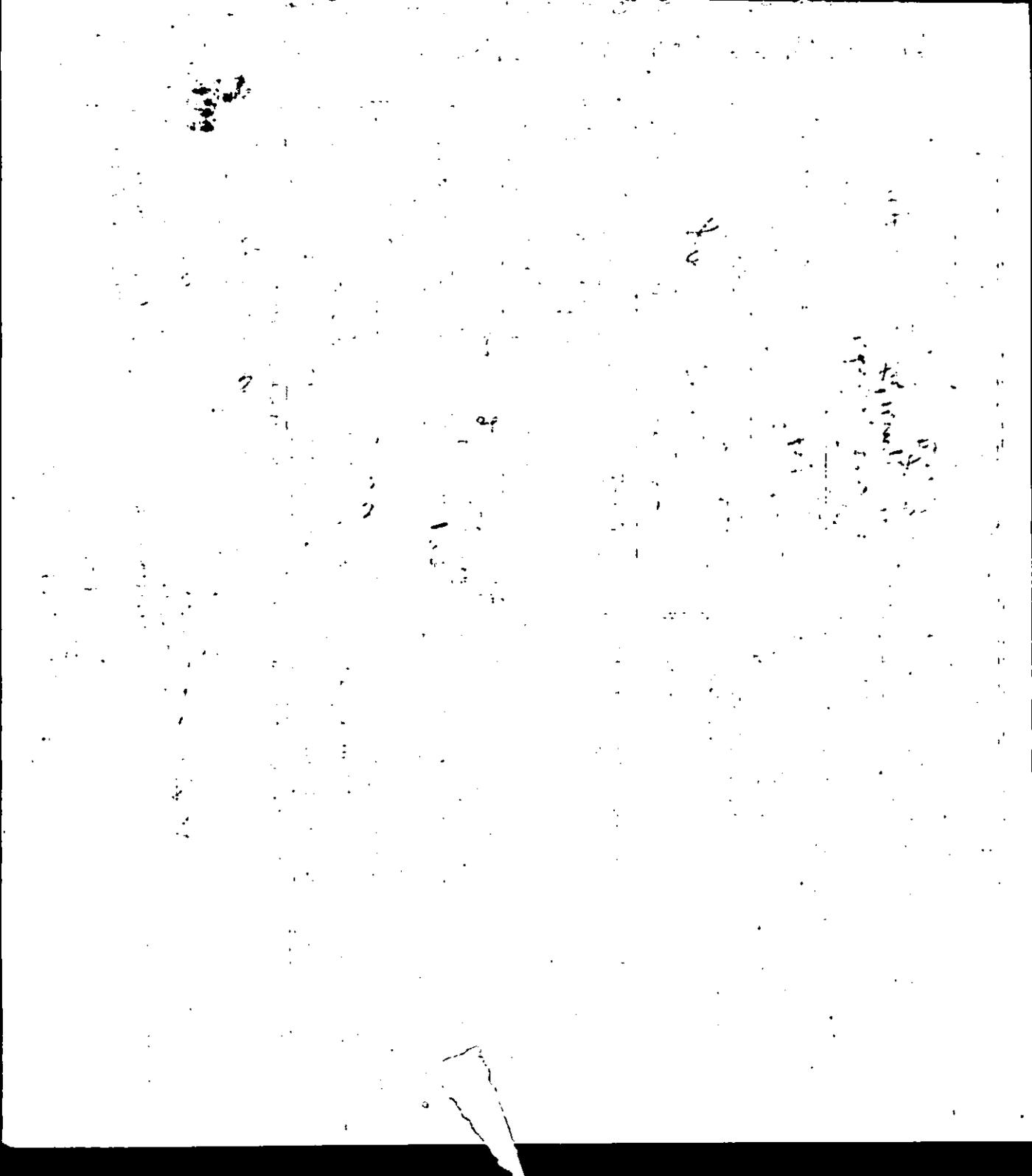
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) [Signature] M. D.
(Address) [Signature]

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.

AUG 21 1934



#2

Kansas City

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

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

3125-

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: Barbara Jean Hobbs
Who died at _____ on July - 14 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

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

Date of birth _____ Age: Years _____ Months 4 Days 28

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 _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Primary Broncho pneumonia (Primary)

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 _____

Signature of Registrar J. M. Brown Date filed _____

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.

Very truly yours,

E. T. McGaugh, M.D.

Special Agent. *T.*

Reg. Dist. No. 399

Primary Reg. Dist. No. 1002

S-24527