

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

Do not use this space.

24936

**1. PLACE OF DEATH**

County Jackson Registration District No. 111  
 Township Ross Primary Registration District No. 111  
 City Kennett (No. 111) K. General Hospital St. 111 Ward 111

**2. FULL NAME**

(a) Residence, No. 1310 Admiral St. 111 Ward. 111  
 (Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 da.

**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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-27-1887

7. AGE YEARS 47 MONTHS 2 DAYS 17 If LESS than 1 day, ..... hrs. or ..... min.

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) Kennett Missouri

13. NAME John Zimmerman

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

15. MAIDEN NAME Katherine Roesier

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

17. INFORMANT (ADDRESS) Rebecca Clark K. General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds Mo DATE July 31 1934

19. UNDERTAKER (ADDRESS) Quinn & Son Co 202 E. Square

20. FILED 7-31-1934 M. M. Brown Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-14-1934

22. I HEREBY CERTIFY, That I attended deceased from 6-9-1934 to 7-14-1934

I last saw him alive on 7-14-1934. Death is said to have occurred on the date stated above, at 8:45 P.M.

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

Brain tumor (subarachnoid cyst) Date of onset 6-9-34  
54

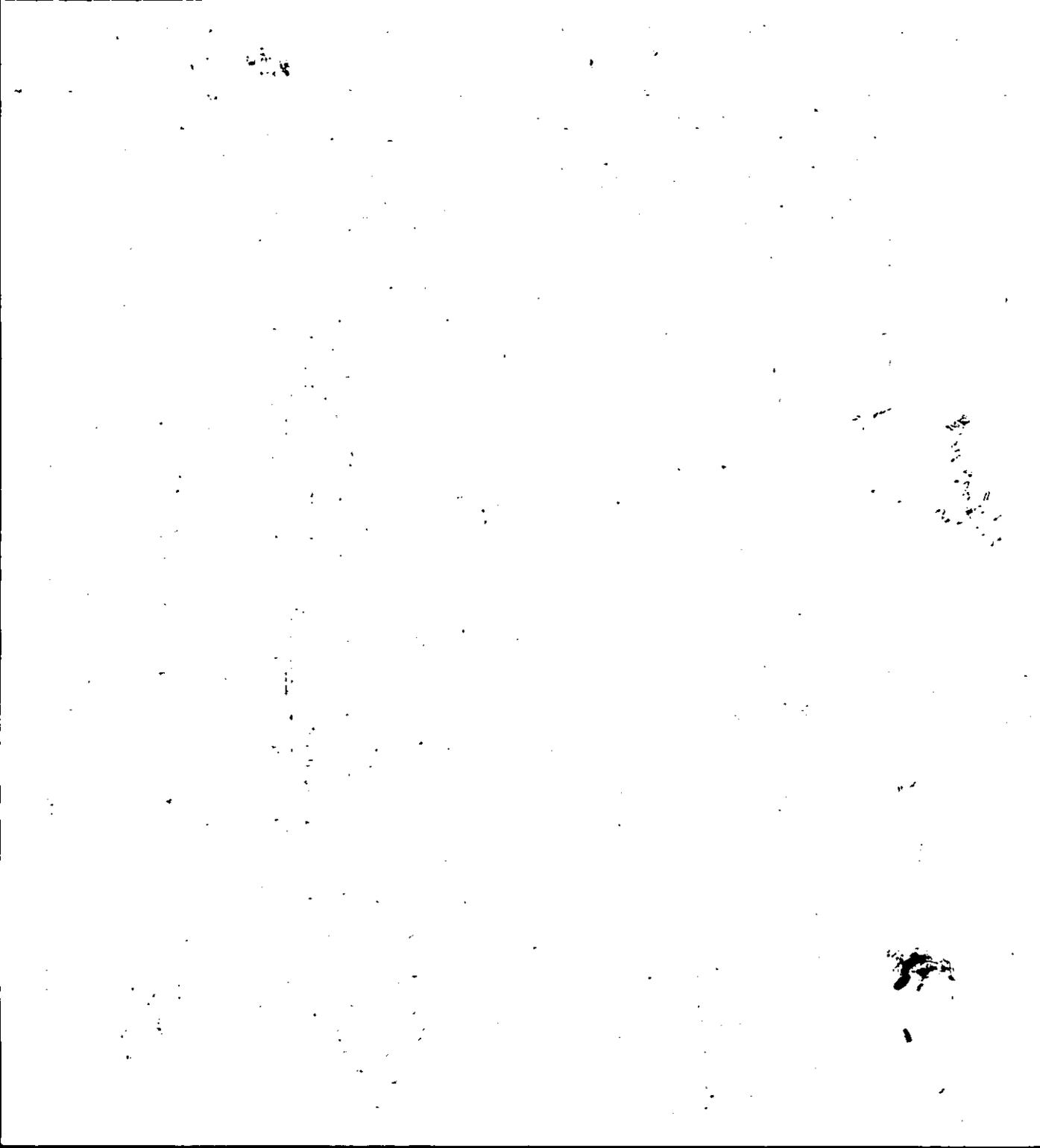
Name of operation Vertebroplasty of lumbar spine Date of 7-9-34  
 What test confirmed diagnosis? 1 Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? 1 Date of injury 19  
 Where did injury occur? 1 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury 1  
 Nature of injury 1

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify 1  
 (Signed) J. J. [Signature], M. D.  
 (Address) 1111 1/2 E. Gen Hosp

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.  
3535-

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: Marie Allen  
Who died at General Hospital on 7-14-34  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex 2 Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 47 Months 2 Days 17

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. 6

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: Brain Tumor (subarachnoid cyst) (not Tuberculosis by malignant)

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 Dr. J. J. Bennett Sup.

Address of physician 1000 Gen. Hospital

Signature of Registrar W. M. Crave asst. Date filed 7/31/34

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,

Reg. Dist. No. 399

E. T. McGaugh, M.D.

Primary Reg. Dist. No. 1002

Special Agent.

5-24986

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