

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 16 1934

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

Don't worry
Do not use this space.
File No. 25434
Registered No. 79
St. _____ Ward)

1. PLACE OF DEATH

County Macon
Township _____
City Macon (No. _____)

Registration District No. 533
Primary Registration District No. 3027

2. FULL NAME Nesnietta Incester

(a) Residence, No. _____ 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 14 1863</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>3</u>
	DAYS <u>5</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Honoree</u>	
	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) <u>Berry</u>		
FATHER	13. NAME <u>John Cross</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Berry</u>	
	15. MAIDEN NAME <u>Nesnietta Incester</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Berry</u>	
	17. INFORMANT <u>Missie Hoopes</u> (ADDRESS) <u>Macon Mo</u>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Widow</u> DATE <u>7/21 1934</u>	
	19. UNDERTAKER <u>Alvin Shuman</u> (ADDRESS) <u>Macon Mo</u>	
	20. FILED _____, 19____ Registrar.	

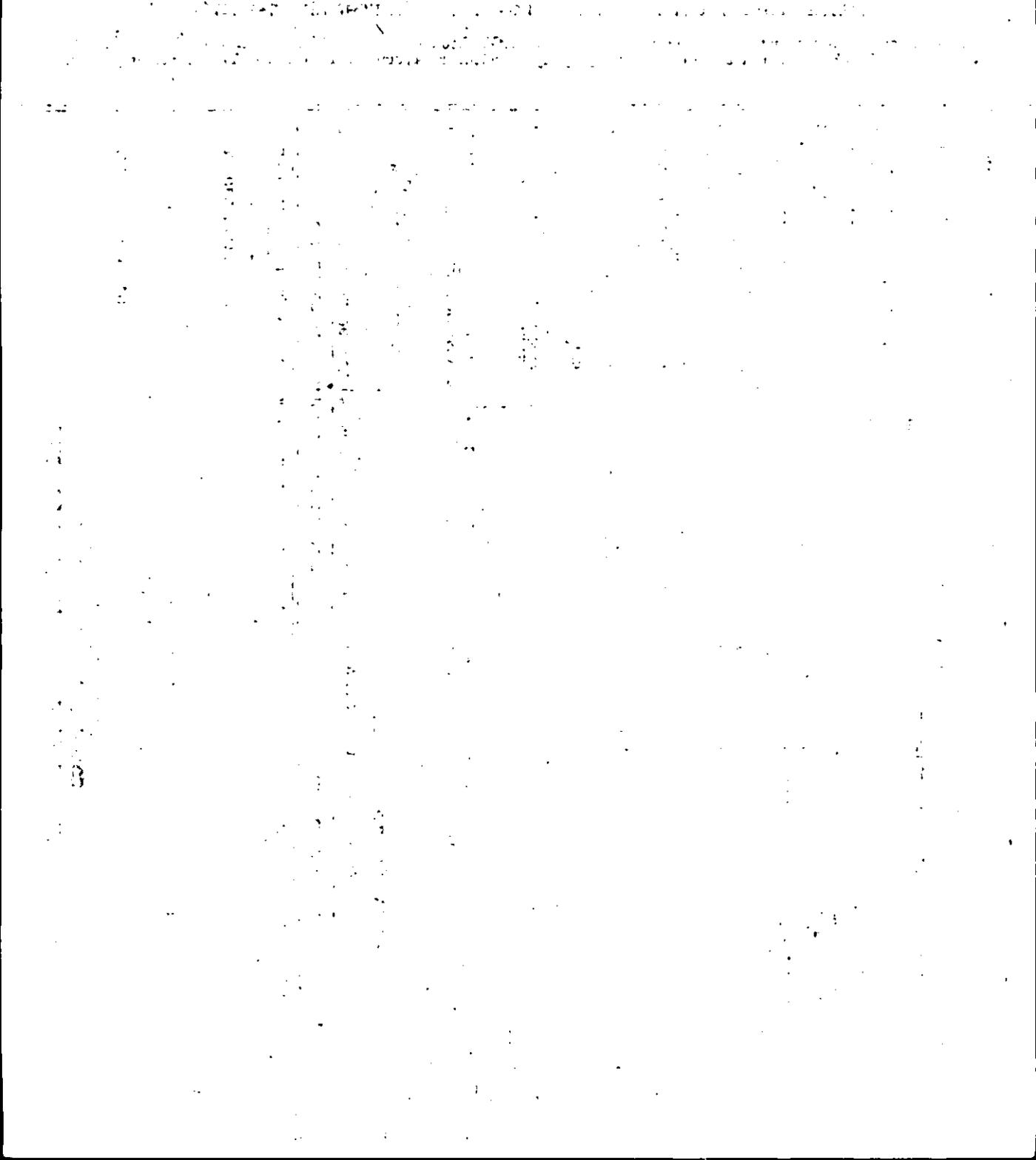
MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/19 1934

22. I HEREBY CERTIFY, That I attended deceased from 7/19 1934, to 7/19 1934.
I last saw him alive on 7/19 1934. Death is said to have occurred on the date stated above, at 7:45 a.m.
The principal cause of death and related causes of importance were as follows:
Heat stroke
1919 B 1919
Cardio-vascular disease
Date of onset 7/19/34
365
Other contributory causes of importance:
Several years
Name of operation Clinical Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

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) D. P. Gray, M. D.
(Address) Macon Mo



#2 *Macou*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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

WASHINGTON

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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: *Hennetta Trooster*
Who died at _____ on *7-19-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

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

Date of birth _____ Age: Years *71* Months *3* Days *5*

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: _____

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 *[Signature]* Date filed *Aug 10, 1934*

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.

Reg. Dist. No. *532* Very truly yours,

Primary Reg. Dist. No. *3027* *E. T. McGaugh, M.D.*
Special Agent.

S 25-434