

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

Do not use this space.

25806

1. PLACE OF DEATH

County Fernisco
Township Concord
City Concord (No. _____)

Registration District No. 653
Primary Registration District No. 5865

File No. 34
Registered No. 34
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 F 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6/10/1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 1 9

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

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) 4/11/1934 11. Total time (years) spent in this occupation 9

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ala

13. NAME Abel Painter

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

15. MAIDEN NAME Amanda

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

17. INFORMANT Jammit Loue
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Concord DATE 7/19 1934

19. UNDERTAKER (ADDRESS) J. Smith

20. FILED 7-19 1934 JWRhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from July 7, 1934 to July 19, 1934
I last saw him alive on July 17, 1934. Death is said to have occurred on the date stated above, at 4:30 a. m.

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

Chronic malaria
1915
1928
1930
Other contributory causes of importance:
Solomon's Bilateral cystitis

Name of operation _____ Date of _____
What test confirmed diagnosis? Sig. Squid 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) A. U. Shier, M. D.
(Address) Hayti, Mo.

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 15 1934

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

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

Illinois

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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: *Natie ~~Deane~~ Lane*
Who died at _____ on *July 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 *B* Single, married, widowed or divorced: _____

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

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) *Chi. Malawi*

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Salpingitis Pelvicum*
Cystitis cause not known. Preperal

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. J. K. [Signature]* 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,

Reg. Dist. No. *653*

Primary Reg. Dist. No. *5865*

E. J. McGaugh m.d.
E. J. C.
Special Agent.