

OCT 17 1934

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

Do not use this space.

1. PLACE OF DEATH

County *Phelps*
Township *Phelan*
City *Phelan* (No. *2*)

Registration District No. *678*
Primary Registration District No. *5902*

File No. *25907*
Registered No. _____
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. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *11-24-1913*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 8 1

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

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) *7-1-34* 11. Total time (years) spent in this occupation *4*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Phelps Co. Mo.*

13. NAME *Wm E Jones*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Phelps Co. Mo.*

15. MAIDEN NAME *Viola A Cox*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Phelps Co. Mo.*

17. INFORMANT (ADDRESS) *Viola A Jones*
Phelan Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE *Masonic Cem* DATE *7-27* 1934

19. UNDERTAKER (ADDRESS) *W. H. Kiehl*
Phelan Mo

20. FILED *7-15* 1934 *W. H. Kiehl* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-25* 1934

22. I HEREBY CERTIFY, That I attended deceased from *July 24* 1934, to *July 25* 1934. Last saw him alive on *July 24* 1934. Death is said to have occurred on the date stated above, at *6:20 P.m.*

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

Post Partum Hemorrhage
1445
1445

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *C. H. Hulse*, M. D.

(Address) *Phelan 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.

