Garrison

SEP 14 1934

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

Do not use this space.

28294

1. PLACE OF DEATH
County Boone — Registration District No. 72
Township — Primary Registration District No. 4041
City Centralia (No. ..... St. ..... Ward)

File No. .....
Registered No. 27

2. FULL NAME Lucy McCarilley
(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~~ Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND~~ OF ~~(OR) WIFE OF~~ G. H. McCarilley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1st 1858

7. AGE — YEARS 75 — MONTHS 10 — DAYS 25 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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) —
11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co., Mo.

FATHER
13. NAME James H McBride
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co., Mo.

MOTHER
15. MAIDEN NAME Agnes Palmer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co., Mo.

17. INFORMANT Hollis McBride
(ADDRESS) Centralia Mo

18. BURIAL, CREMATION, OR REMOVAL
Centralia Mo Cem DATE Aug 27 1934

19. UNDERTAKER M. J. McDonald
(ADDRESS) Centralia Mo

20. FILED 8/27th 1934 Registrar.

MEDICAL CERTIFICATE OF DEATH

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21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26, 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1934, to Aug. 26, 1934
I last saw her alive on Aug. 25, 1934. Death is said to have occurred on the date stated above, at 5 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Typhoid Fever	Aug. 19

Other contributory causes of importance:
Hypostatic Pneumonia — Aug. 24

Name of operation ..... Date of .....
What test confirmed diagnosis? Widal 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. L. Garrison, M.D.
(Address) Centralia, 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.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Boone — Registration District No.: 72
Township: — Primary Registration District No.: 4041
City: ..... (No. ....., ..., St. ....., Ward)

File No.:
Registered No.:

2. FULL NAME: Lucy McCauley
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): W

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

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

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

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19....

19. UNDERTAKER (ADDRESS)

20. FILED ....., 19.... J. E. Hickerson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26, 1934

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... 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:

	Date of onset

Other contributory causes of importance:

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) ....., M. D.
(Address) .....

SUPPLEMENTARY

S-28294