

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.

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

Do not use this space.

32886

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kennett Primary Registration District No. 100 Registered No. 42128
 City Vineyard Care Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Liberty, Mo. R#2 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. 4 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>Married</u> | |
| 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas J. Scabill</u> | | | | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Apr - 5 - 1896</u> | | | | | |
| 7. AGE | | YEARS | | MONTHS | |
| <u>38</u> | | <u>5</u> | | <u>11</u> | |
| 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. | | 10. Date deceased last worked at this occupation (month and year) | | | |
| <u>Homewife</u> | | <u>In sep 1934</u> | | | |
| 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. | | 11. Total time (years) spent in this occupation. | | | |
| <u>In sep</u> | | <u>10 7/8</u> | | | |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kennett, Mo</u> | | | | | |
| 13. NAME <u>Chamney, Florida</u> | | | | | |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u> | | | | | |
| 15. MAIDEN NAME <u>Anna</u> | | | | | |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u> | | | | | |
| 17. INFORMANT <u>Thos. J. Scabill</u> | | | | | |
| 18. BURIAL, CREMATION, OR REMOVAL <u>Liberty, Mo</u> | | | | | |
| 19. UNDERTAKER (ADDRESS) <u>W. H. Crowe</u> | | | | | |
| 20. FILED <u>9-16-34</u> M. M. Crowe Registrar. | | | | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 16, 1934

22. I HEREBY CERTIFY, That I attended deceased from Sept - 13, 1934, to Sept 16, 1934
 I last saw her alive on Sept 16, 1934 Death is said to have occurred on the date stated above, at 2:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of uterus 1933
 Other contributory causes of importance:
Bronchitis - pneumonia
filling of pulmonary artery 9-14-34
 Name of operation myectomy Date of 9-13-34
 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) J. B. Sheldon, M. D.
 (Address) 822 Walnut
KS Mo

