

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.

OCT 22 1934

33574

1. PLACE OF DEATH

County *Madison* Registration District No. *620*
Township *Jefferson* Primary Registration District No. *4371*
City *Jefferson* (No. _____) St. _____ Ward _____

2. FULL NAME

(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 *54* 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *8-9-1862*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>72</i>	<i>1</i>	<i>0</i>	

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) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Atchison, Mo.*

MOTHER FATHER

13. NAME *John Smith*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison, Missouri*

15. MAIDEN NAME *Mary A. Brandt*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison, Missouri*

17. INFORMANT (ADDRESS) *Conception Jones*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Conception, Mo.* DATE *9-10-34*

19. UNDERTAKER (ADDRESS) *Conception, Mo.*

20. FILED *Sept 10 1934* *Mabel Graham* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-9-34*

22. I HEREBY CERTIFY, That I attended deceased from *July 1* 19*34*, to *Sept 4* 19*34*. I last saw her alive on *Sept 4* 19*34*. Death is said to have occurred on the date stated above, at *3 P.* m. The principal cause of death and related causes of importance were as follows:

Carcinoma thyroid gland
535
536
53

Other contributory causes of importance: *metastasis to brain & liver*

Name of operation *none* Date of _____
What test confirmed diagnosis? *Chemical* 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 *none*
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) *J. M. Boyles* M. D.
(Address) *Conception, Mo.*

53.5
10
12

