

NOV 14 1934

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

Do not use this space.

35766

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(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.

Ward.

(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
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Grey Bolles		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24 - 1871		
7. AGE	YEARS 63	MONTHS 1
	DAYS 23	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. In home	
	10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....	

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.
	13. NAME - Mansholder
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.
	15. MAIDEN NAME Sarah Brown
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
	17. INFORMANT (ADDRESS) Grey Bolles, Springfield, Mo.
18. BURIAL, CREMATION, OR REMOVAL Maple Park Cemetery, Oct 19 1934	
19. UNDERTAKER (ADDRESS) F. W. Lingner & Co., Springfield, Mo.	
20. FILED 10-17 1934	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-17-1934	1934
22. I HEREBY CERTIFY, That I attended deceased from 3-24-1934 to 10-17-1934	
I last saw her alive on 10-17-1934 Death is said to have occurred on the date stated above, at 4 p.m.	
The principal cause of death and related causes of importance were as follows: Carcinoma about Primary in breast.	
Other contributory causes of importance: Carcinoma Metastatic	
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. E. Feller, M. D. (Address) Springfield, 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.

WHITE - PAINTLY, WITH UNFADING MARKS TO THE STERNUM

