

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.

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Dr Gronoway

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

Do not use this space.

JAN 8 1935

40017

1. PLACE OF DEATH

County *Macon*
Township *Macon*
City *Macon* (No.)

Registration District No. *533*
Primary Registration District No. *3027*

File No.
Registered No. *127*
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 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 *Negro* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug. 24 - 1878*

7. AGE YEARS *56* MONTHS *3* DAYS *4* If LESS than 1 day, hrs. or min.

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. *House work*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation *71*

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

13. NAME *Chp. Austin*

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

15. MAIDEN NAME *Mariah D.K.*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *D.K.*

17. INFORMANT *Mrs Joe Arcit* (ADDRESS) *Macon Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Woodlawn* DATE *12-1-1934*

19. UNDERTAKER *Stephens & Goodburg* (ADDRESS) *Macon Mo*

20. FILED *1210* 19 *39* *Lene Clark* Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/28*, 19*34*

22. I HEREBY CERTIFY That I attended deceased from *July 20*, 19*34* to *Nov 28*, 19*34*

I last saw h. alive on *Nov 26*, 19*34* Death is said to have occurred on the date stated above, at *9:00 a.m.*

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

Fibro-myoma uterus with marked hemorrhages producing marked

Other contributory causes of importance: *Secondary Anemia about July 1934*

Name of operation *Clinical* Date of

What test confirmed diagnosis? *Radiology* 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) *J. Gronoway* M. D. (Address) *Macon Mo*

JAN 20 1942

**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 Macon
Township _____
City Macon (No. _____)

Registration District No. 533
Primary Registration District No. 3027

File No. _____
Registered No. 124
St. _____ Ward _____

2. FULL NAME

Mollie Green

(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE B 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.
56 3 4

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) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

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. FILE No 10 19 34 Kane Cross
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 28 19 34

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:

Leiomyoma of uterus Date of onset 3?

metastatic malignant

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

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.

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

JAN 3 1 1935

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