

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.

11
5
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31
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2

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

Do not use this space.

568 FEB 20 1935

1. PLACE OF DEATH

County Bucaranan

Township

City St. Joseph

Registration District No.

85

1001

Primary Registration District No.

(No. State Hospital #2)

File No.

282

Registered No.

106

St. _____ Ward _____

2. FULL NAME Mary Myers

Mary Myers

(a) Residence, No. St. Joseph, Mo. St. _____ Ward _____

Length of residence in city or town where death occurred Unknown mos.

(If nonresident, give city or town and State)
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) widow

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF myers

7. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 28, 1864
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 11 7 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Female State Hospital
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) Unknown

13. NAME William Shay Robinson

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

15. MAIDEN NAME Caroline Steele

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hosp. Records

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cemetery DATE Jan. 26, 1935

19. UNDERTAKER (ADDRESS) Walter Meierhoffer
1302 Paragon St., St. Joseph, Mo.

20. FILED 1-25-35 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 24, 1935

22. I HEREBY CERTIFY, That I attended deceased from May, 1929, to January 24, 1935

I last saw her alive on January 23, 1935. Death is said to have occurred on the date stated above, at 3 a.m.

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

Carcinoma of Uterus Date of onset Indefinite

Other contributory causes of importance: none

Name of operation _____ Date of _____

What test confirmed diagnosis Clinical 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) G. W. Garrison M. D.

(Address) State Hospital No. 2, St. Joseph, Mo.

$$\begin{array}{r} 1935-1^2 = 24 \\ 70-11 = \underline{59} \\ \hline 1864-2 = 22 \end{array}$$