

Hickerson

JUN 1 8 1935

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

Do not use this space.

15579

1. PLACE OF DEATH
County Brown Registration District No. 92
Township _____ Primary Registration District No. 4041
City Centralia (No. _____) St. _____ Ward _____

2. FULL NAME Mary Elizabeth Mayer
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Drew Mayer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-31-1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
92 4 22

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Handsewer
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 COUNTY) Anderson Co Mo.

13. NAME Lewis A. James

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

15. MAIDEN NAME Bedgway

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

17. INFORMANT Mertie Mayer (ADDRESS) Centralia Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Centralia DATE May 25 1935

19. UNDERTAKER M. J. Medard (ADDRESS) Centralia Mo

20. FILED 5244 1935 J. H. Hickerson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23 1935

22. I HEREBY CERTIFY, That I attended deceased from April 11, 1935, to May 23, 1935.

I last saw h. or alive on May 22, 1935. Death is said to have occurred on the date stated above, at 12:35 P.M.

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

Pain of Pleur Date of onset 4-11
810
Other contributory causes of importance: Bronchial pneumonia 5-20

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 _____

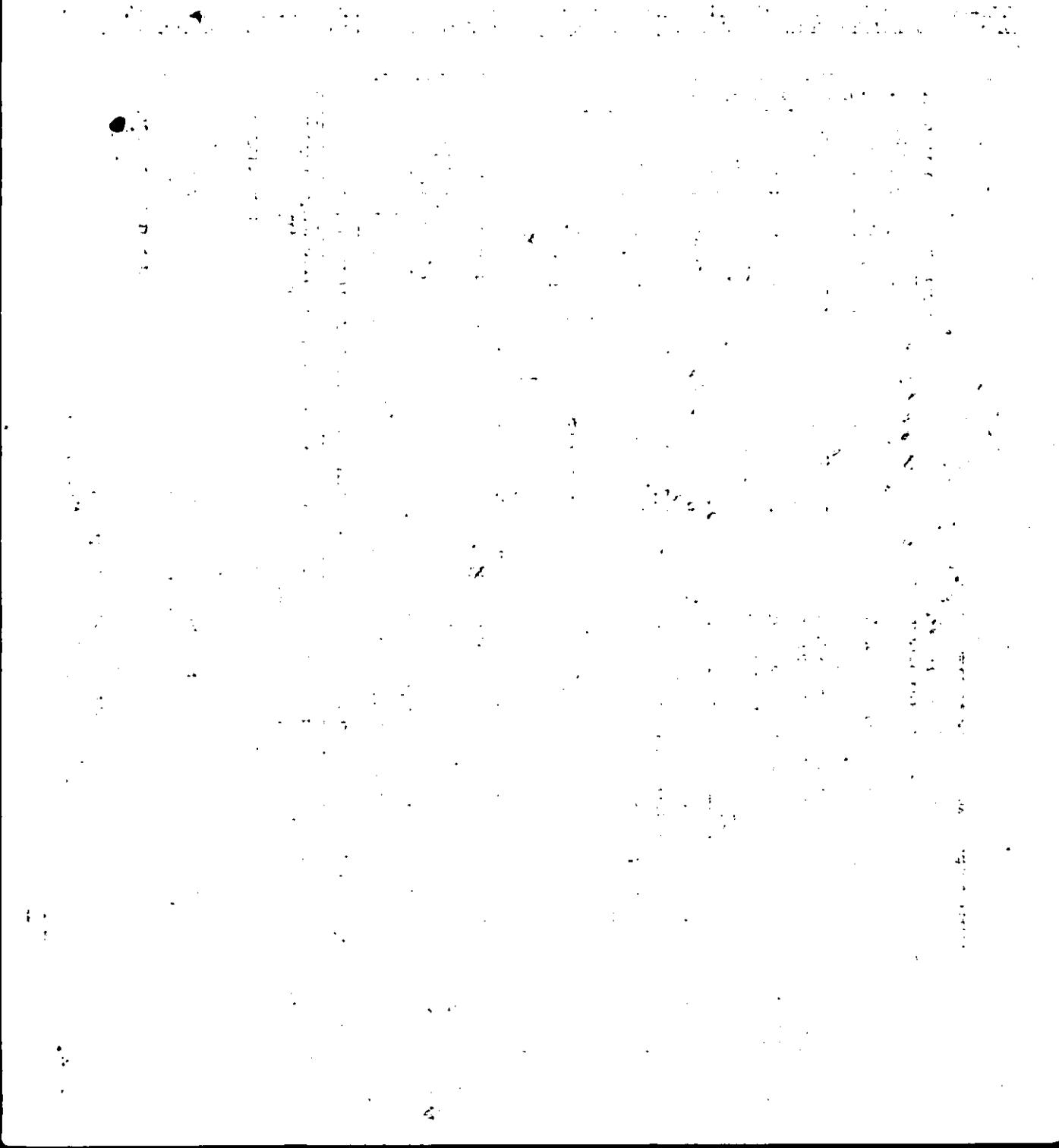
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) J. H. Hickerson, M. D.
(Address) Centralia 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.

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

Do not use this space.

1. PLACE OF DEATH

County Boone Registration District No. 72 File No. _____
 Township _____ Primary Registration District No. 4041 Registered No. 14
 City Centralia (No. _____) St. _____ Ward _____

2. FULL NAME Mary Elizabeth Mayes
 (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 F **4. COLOR OR RACE** W. **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** W
 (write the word)
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.**
92 4 22

OCCUPATION
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. FILED May 24 1935 J. F. Hickerson
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____, 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:

paralytic
paraplegia
atroc.
 Date of onset _____
 Other contributory causes of importance:
Bronchial pneumonia

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) _____

SUBSTITUTED

JUL 1 1935

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