

JUN 19 1935

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

Do not use this space.

19120

1. PLACE OF DEATH

County Callaway Registration District No. 1111
Township Cleveland Primary Registration District No. 5160
City Keokuk (No. _____) St. _____ Ward _____

2. FULL NAME

Mrs. Mollie M^cCray
(a) Residence, No. Keokuk, Mo 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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-19-1870
7. AGE YEARS 64 MONTHS 8 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.

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) Missouri
13. NAME John Threlkeld
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
15. MAIDEN NAME Betty Shyrock
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT Wife M^cCray (ADDRESS) Keokuk, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Millersburg, Mo DATE 6-3, 1935

19. UNDERTAKER John Furniture Co. (ADDRESS) Keokuk, Mo
20. FILED June 10, 1935 B. H. Stephens Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 1, 1935
22. I HEREBY CERTIFY, That I attended deceased from Jan. 1927, 1927, to June 1, 1935
I last saw h^e alive on _____, 19____. Death is said to have occurred on the date stated above, at 8:30 p. m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemiplegy Date of onset 1927
Other contributory causes of importance: Arteriosclerosis 1910

Name of operation None Date of _____
What test confirmed diagnosis? _____ 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) W. D. Deason, M. D.
(Address) Keokuk, Mo.

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.

