

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.

DEC 11 1935

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

Do not use this space.

35238

1. PLACE OF DEATH

County Cochran 4

Registration District No. 35

File No. _____

Township _____

Primary Registration District No. 1001

Registered No. 1209

City St. Joseph (No. _____)

State Mo. +2 Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. Dodginger, mo

(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) widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-1-1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ormin.
	<u>77</u>	<u>8</u>	<u>19</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housekeeper

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) Ohio unknown

13. NAME John Gray

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio unknown

15. MAIDEN NAME Elizabeth Argenter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio unknown

17. INFORMANT (ADDRESS) Records City Hosp. St. Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Dodginger, Mo. DATE Nov. 20 1935

19. UNDERTAKER (ADDRESS) Lawellson & Son Dodginger Mo

20. FILED 11-20 1935 John N. Beude Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 20 1935

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1935, to 11/20 1935

I last saw her alive on Nov 20 1935. Death is said to have occurred on the date stated above, at 11:45 a. m.

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

Lobar pneumonia Date of onset 11/15/35

Other contributory causes of importance: 10

Name of operation _____ 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. Clayton Smith M. D.

(Address) State Hosp #2 St. Joseph Mo

