

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

Do not use this space.

DEC 26 1935

36065

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Law Primary Registration District No. 1202  
 City St. Joseph, Mo. (No. St. Josephs Hosp. St.            Ward)

File No.             
 Registered No.           

**2. FULL NAME**

Mildred Daniels  
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12-1915-

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
20 5 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Bookkeeper  
 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) Butler Mo

13. NAME Rome Daniels

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

15. MAIDEN NAME Ada Deweese

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Butler Mo

17. INFORMANT (ADDRESS) Rome Daniel

18. BURIAL, CREMATION, OR REMOVAL PLACE Butler Mo DATE 12/13 1935

19. UNDERTAKER (ADDRESS) Leysers Butler Mo

20. FILED Nov. 11, 1935 M. M. Carrowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-11-35

22. I HEREBY CERTIFY That I attended deceased from Deputy Coroner, 1935  
 I last saw him            alive on           , 1935 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:

Fractured Skull Date of onset             
Multiple Brain Hemorrhage

Other contributory causes of importance:  
(Concussion) 1/26/35

Name of operation None Date of             
 What test confirmed diagnosis?            Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident,            Date of injury 11/10 1935

Where did injury occur? Jackson Co. Mo. (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fell from horse  
 Nature of injury Fracture of skull

24. Was disease or injury in any way related to occupation of deceased? If so, specify             
 (Signed) M. M. Carrowe (Address) St. Joseph Hospital

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.

