

DEC 19 1935

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

Do not use this space.

36820

## 1. PLACE OF DEATH

County *New Madrid*Registration District No. *605*

File No. ....

Township *Osage*Primary Registration District No. *4359*

Registered No. ....

City *Reese* (No. ....)

St. .... Ward)

## 2. FULL NAME

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *infant*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar 24 1935*7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min. *7 27*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) *Reese Mo*13. NAME *Thomas Long*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*15. MAIDEN NAME *Celia Walker*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ark*17. INFORMANT (ADDRESS) *Thomas Long*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Malden* DATE *11-21* 19 *35*19. UNDERTAKER (ADDRESS) *none*20. FILED *11-20* 19 *35* *Dr. George J. ...* Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11-20* 19 *35*22. I HEREBY CERTIFY, That I attended deceased from *11-7* 19 *35* to *11-20* 19 *35*.I last saw him alive on *11-15* 19 *35*. Death is saidto have occurred on the date stated above, at *7 A* m.

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

*Colitis - Diarrhea*Date of onset *11-1-35*

Other contributory causes of importance:

Name of operation .....

What test confirmed diagnosis? *Choloid* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? .....

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) *A. F. Breckner*, M. D.(Address) *Parma*

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.

