

JAN 21 1936

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

Do not use this space.

1. PLACE OF DEATH

County Wright
Township Mt. Grove, Mo.
City Mt. Grove, Mo. (No. _____)

Registration District No. 908
Primary Registration District No. 4549

File No. 4363
Registered No. 82
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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 29-1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41 3 7

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) Keosauqua, Mo.

13. NAME Frank Broth

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

15. MAIDEN NAME Etha Price

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

17. INFORMANT (ADDRESS) Albert Peberry

18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview DATE 1-7-1936

19. UNDERTAKER (ADDRESS) Boston Funeral Home

20. FILED 1-7 1936 Berice Montgomery Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6 1936

22. I HEREBY CERTIFY That I attended deceased from Aug. 20 1935 to Jan 6 1936

I last saw him/her alive on Jan 5 1936. Death is said to have occurred on the date stated above, at 12:10 PM.

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

Uræmia Recent attack Influenza
Date of onset 1-5-36

Other contributory causes of importance: Chronic laryngitis Chronic glomerulonephritis Chronic edipic hypertension Pregnancy

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 _____ 1936

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 _____

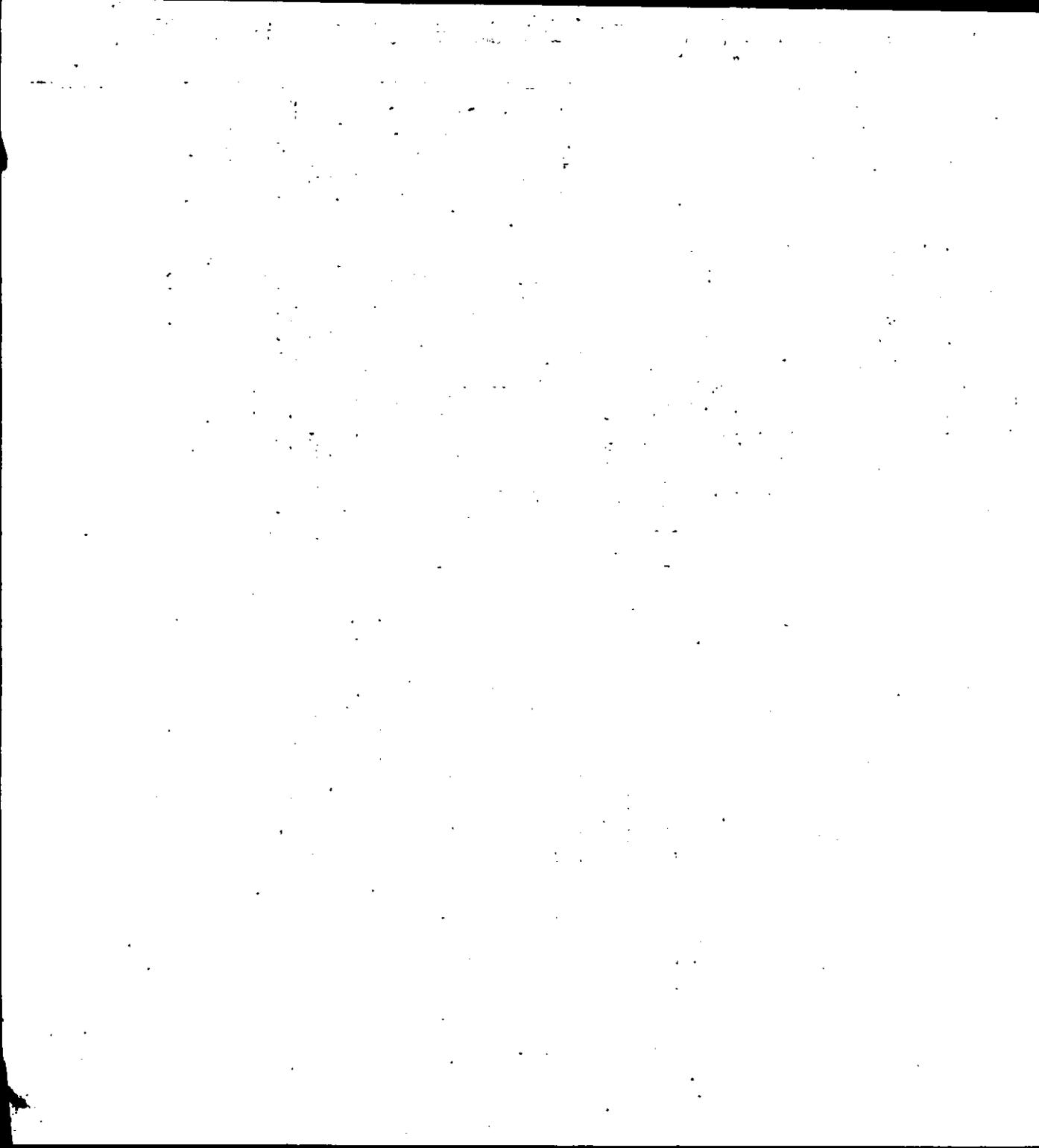
24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) A. H. France, M. D.

(Address) Mt. Grove, 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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1. PLACE OF DEATH

County Wright
Township _____
City _____ (No. _____)

Registration District No. 908
Primary Registration District No. 4549

File No. 4363
Registered No. 82
St. _____ Ward _____

2. FULL NAME Mary B. W. Reberg

(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 m
(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.
41 3 7

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 6-9- 1936 Bernice Montgomery (Address) Mtn. Grove Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6 1936

HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____.

I last saw h_____ alive on _____, 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:

Ch. Parenchymatous nephritis
Yes Chronic
Other contributory causes of importance:
previous to pregnancy
Pregnancy

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) A. P. Frazer _____ M. D.
(Address) Mtn. Grove Mo

NOTE.—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.

SUPPLEMENTARY

S-4363