

APR 23 1936

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

Do not use this space.

10641

1. PLACE OF DEATH

County Jackson
Township Ray mo
City Ray mo (No. General Hosp. #2)

Registration District No. 399
Primary Registration District No. 1002

File No. 1308
Registered No. 3rd Ward

2. FULL NAME

(a) Residence, No. 618 Cottage Lane Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-4-1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 2 2

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

Domestic

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) Art.

13. NAME Madison Lovett

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

15. MAIDEN NAME Jennie Shackelford

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

17. INFORMANT (ADDRESS) Record Clerk General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Lawn DATE 3/11 1936

19. UNDERTAKER (ADDRESS) Watkins Bros 1729 Lydia

20. FILED Feb 11, 1936 M. M. Corum Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-6, 1936

22. I HEREBY CERTIFY, That I attended deceased from 2-4, 1936, to 3-6, 1936

I last saw her alive on 3-6, 1936 Death is said to have occurred on the date stated above, at 10:38 A.M.

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

Gas Gangrene
(Cause unknown)
Infection following
 vaginal hysterectomy

Other contributory causes of importance: 500W

Multiple Infarcts
Large Bifurcated

Name of operation 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, suicide, or homicide? Date of injury

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

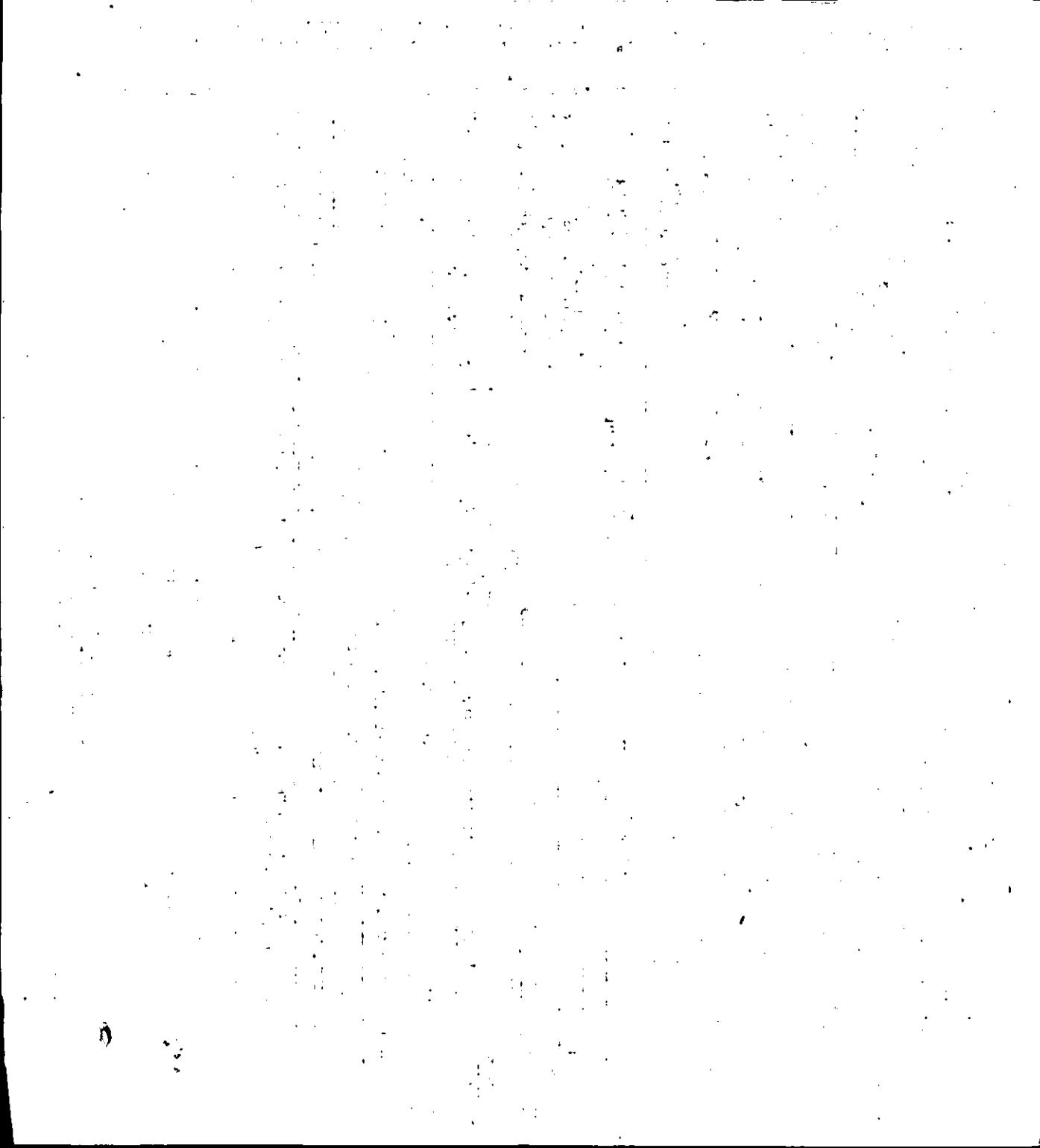
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify (Signed) J. C. [Signature] M. D.

(Address) General Hosp. #2

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..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 1308
City..... (No. General Hospital) St. Ward)

2. FULL NAME

Fannie George
(a) Residence, No. St. Ward.
(Usual place of abode)

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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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 day, hrs. or min.

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 3/11, 1936 M. A. Groves
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

..... last saw h..... alive on, 19..... Death is said

to have occurred on the date stated above, at

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

Gas gangrene Date of onset

Vaginal hysterectomy for

fibroid uterus - non malignant

Other contributory causes of importance:

Name of operation Complete hysterectomy Date of

What test confirmed diagnosis? Biopsy Was there an autopsy? yes

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), M. D.

(Address)

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.

SUPPLEMENTAL

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