

JUL 29 1936

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

Do not use this space.

1. PLACE OF DEATH

County Stone
Township Union
City (No. _____) _____ St. _____ Ward _____

Registration District No. 846
Primary Registration District No. 6110

File No. 25249
Registered No. 13

2. FULL NAME Mary Jane Raper

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 11 18

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

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) La.

13. NAME H. M. Rhodes

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Mrs. Charley Skaggs
Ozark, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Carmel DATE June 9 - 1936

19. UNDERTAKER (ADDRESS) J. W. Maples
Clevers, Mo.

20. FILED 7-10- 1936 H. G. Thompson
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8 - 1936

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1936, to June 8, 1936
I last saw her alive on June 8, 19____. Death is said to have occurred on the date stated above, at 4:30 P.M.
The principal cause of death and related causes of importance were as follows:

Abscess of Left Lung Date of onset Jan

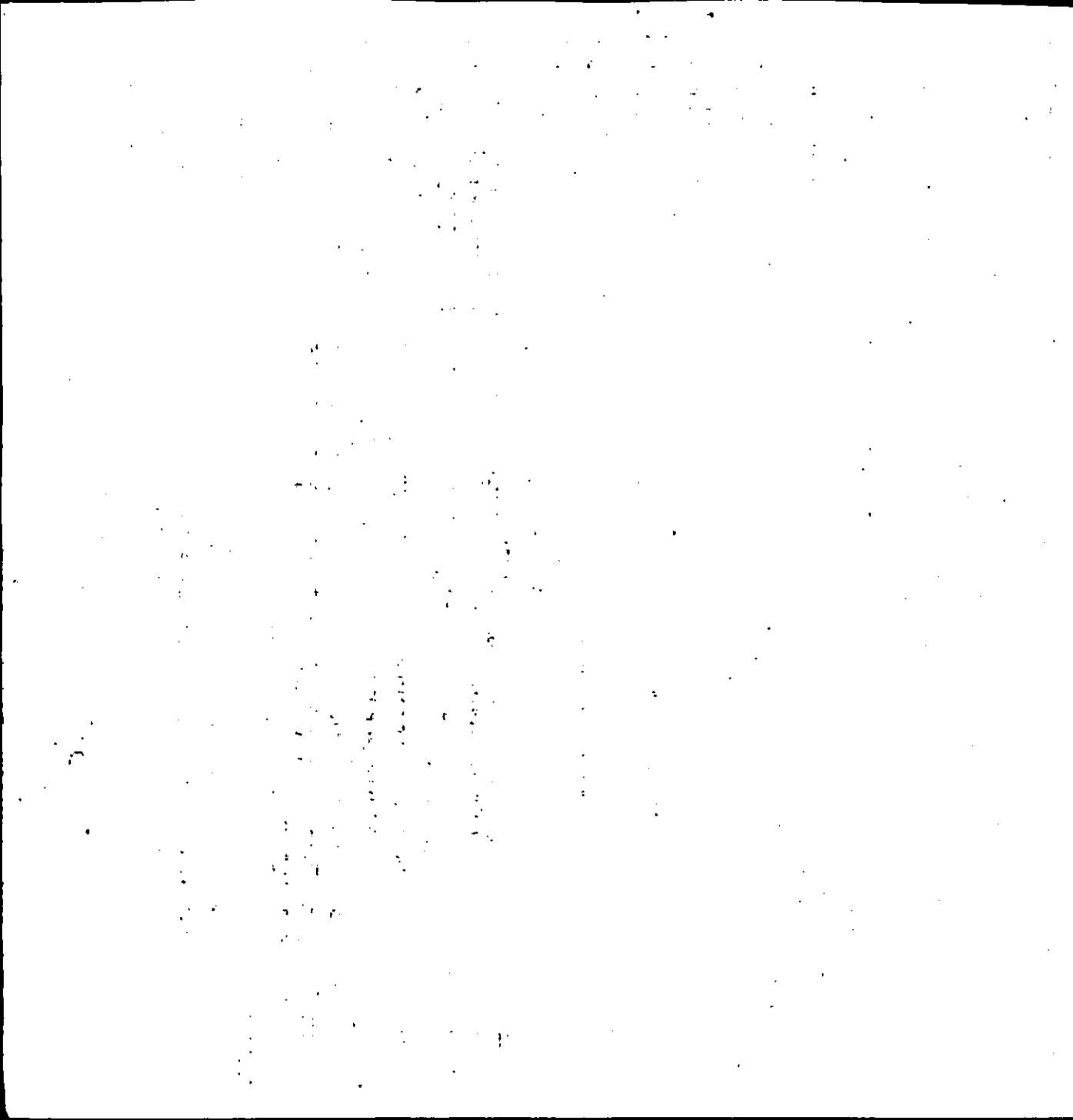
Other contributory causes of importance: Arteriosclerosis (Bioschol) 1910

Name of operation _____ Date of _____
What test confirmed diagnosis? None 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? no
If so, specify _____
(Signed) P. M. Harris, M. D.
(Address) Chm. ind



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1. PLACE OF DEATH

County Stone

Registration District No. 846

File No.

Township Union

Primary Registration District No. 6110

Registered No.

City No.

St. Ward)

2. FULL NAME

Mary Jane Paper

(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) m

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. 73 11 18

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 7-10-1936 J. J. Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-8 1936

22. I HEREBY CERTIFY, That I attended deceased from

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

I last saw him 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:

abscess of lung
Pulmonary Tuberculosis

Date of onset

Jan 1935

(Other contributory causes of importance:

23

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) E. Williams, M. D.

(Address) Clover Mo.

5-25249