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.

JUN 17 1936

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

Do not use this space.

1. PLACE OF DEATH
County Chariton
Township [illegible]
City [illegible]
Registration District No. 173
Primary Registration District No. 5240
File No. 48260
Registered No.
(No. , St. Ward)

2. FULL NAME not named
(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
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)
7. AGE YEARS — MONTHS — DAYS — If LESS than 1 day, 7 hrs. or 7 min.

OCCUPATION
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) Salisbury Missouri

FATHER
13. NAME —
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bernard Habeln Salisbury

MOTHER
15. MAIDEN NAME Josephine Schruette
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Salisbury Mo

17. INFORMANT (ADDRESS) Mrs B. H Abeln - Salisbury
18. BURIAL, CREMATION, OR REMOVAL
PLACE Salisbury DATE May 13 1936
19. UNDERTAKER (ADDRESS) Home - attendant
20. FILED May 13 1936 J. D. McAdam Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12 1936
22. I 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:
Excessive amt amniotic fluid, and Defective Development
Date of onset
Other contributory causes of importance:
Cervical Spinal Bifida
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? X
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? X
If so, specify
(Signed) J. D. McAdam, M. D.
(Address) Prairie Hill Mo

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (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 | 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 1 day, .....hrs. or .....min. |
|---|---|---|---|---|
| | | | | |

OCCUPATION

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)

FATHER

13. NAME

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

MOTHER

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....., 19..... .....
*Registrar.*

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I 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:

| | Date of onset |
|---|---|
| | |
| | |
| | |
| | |
| | |
| Other contributory causes of importance: | |
| | |
| | |
| | |

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)....., M. D.

(Address).....

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.