

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Do not use this space.

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

**JUN 17 1937**

Do not use this space.

**1. PLACE OF DEATH**

County Callaway  
Township Fulton  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 104  
Primary Registration District No. 3008

File No. 10617  
Registered No. 122  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs. Johanna Kathrine Ismay

(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) Widowed

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

3/2 1847

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

7. AGE 90 YEARS MONTHS 3 DAYS 0 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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) Gr.

FATHER 13. NAME Will Leers

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

MOTHER 15. MAIDEN NAME Margret Mertins

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

17. INFORMANT Mrs. Earl Brown Fulton Mo.  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillcrest Cemetery DATE 5/4 37 19.

19. UNDERTAKER Herndon Taylor Fulton Mo.  
(ADDRESS)

20. FILED May 3, 1937 R. M. Creed  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2, 1937

22. I HEREBY CERTIFY, That I attended deceased from March 18, 1937, to May 2, 1937

I last saw her alive on May 1, 1937. Death is said to have occurred on the date stated above, at 1:10 A.m.

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

Abdominal Carcinoma

Date of onset 3/18 '37

Other contributory causes of importance: Ho

General Senility  
Anemia (Secondary)

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? Lab. Was there an autopsy? No.

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) L. C. E. Hutchins, M.D., M.P.H.

(Address) Fulton - Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Callaway Registration District No. 104 File No. 19617  
 Township \_\_\_\_\_ Primary Registration District No. 3008 Registered No. \_\_\_\_\_  
 City Fulton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Johanna Katherine Penney  
 (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 10 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid  
 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.  
90 3 0

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. FIL July 22 37 R. N. Crews Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 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:

abdominal carcinoma Date of onset \_\_\_\_\_  
Body was not Autopsied, but the malignancy probably involved the Liver, Small Intestine & Kidneys  
 Other contributory causes of importance: \_\_\_\_\_  
Primary lesion of unknown

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) Clayton E. Hetchins, M. D. O  
 (Address) Fulton, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1991

2004

1996/5