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AUG 25 1937MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

27616

## 1. PLACE OF DEATH

County

Township

City

## 2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St., \_\_\_\_\_ Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

Ward \_\_\_\_\_

## 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)

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. UNDERTAKER

(ADDRESS)

20. FILED

1937

Faye B. Bales

Registrar

## MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY That I attended deceased from

month 12, 1937 to July 29, 1937

I last saw her alive on July 27, 1937 at 1:30 am

to have occurred on the date stated above, at \_\_\_\_\_

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

Date of onset

Myocardial Infarction (acute)

Other contributory causes of importance

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? P. A. 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 \_\_\_\_\_ 1937

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)

(Address)

G. P. West, M. D.  
Lexington, 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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

27616  
Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. 461  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3024 Registered No. 64  
 (c) City Leopold (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Paralee Jackson  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 17 4. COLOR OR RACE col 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.  
39 8 12

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct 5 19\_\_ Faye B. Bates Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 30, 1932

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:

Myocardial infarction  
with  
hypertension  
and  
coronary atherosclerosis  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:

Myocardial hemorrhage  
and  
myocardial infarction  
with  
hypertension  
and  
coronary atherosclerosis

What 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) J. G. West, M. D.

(Address) Leopold mo

SUPPLEMENTARY

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.

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

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