

SEP 21 1937

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

Do not use this space.

39932

1. PLACE OF DEATH

County Jackson  
Township Ray  
City Ray Mo.

Registration District No. 399  
Primary Registration District No. 1007  
General Hosp.

File No. \_\_\_\_\_  
Registered No. 3539  
Ward 3

2. FULL NAME

(a) Residence, No. 2309 Forest 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-28-37

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
				<u>45 min.</u>

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. (none)

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) Ray Mo.

13. NAME Oliver Brown

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

15. MAIDEN NAME Aileen Chinn

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

17. INFORMANT (ADDRESS) Record Clerk General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Depts. Mo. DATE Aug 30, 37

19. UNDERTAKER (ADDRESS) West, Appleton & Sons 11901 Vermont

20. FILED Aug 30, 37 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-28 1937

22. I HEREBY CERTIFY, That I attended deceased from 8-28, 1937, to 8-28, 1937. I last saw her alive on 8-28, 1937. Death is said to have occurred on the date stated above, at 4:05 PM. The principal cause of death and related causes of importance were as follows: Asphyxiation (severe)

Other contributory causes of importance: 161 Q

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis Clinical 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? No  
If so, specify \_\_\_\_\_ (Signed) O. O. Brown M. D.  
(Address) General Hosp. # 2

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.

1 X 3014

