

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

Do not use this space.



OCT 19 1937

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1003
 City Raw (No. Wesley Hospital) St. _____ Ward _____

File No. 33189
 Registered No. 3052

2. FULL NAME

(a) Residence, No. Lexington Mo. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 6, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1937, to Sept. 6, 1937

I last saw her alive on Sept. 6, 1937. Death is said to have occurred on the date stated above, at 3:00 p.m.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29 - 1917
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 20 1 7

Postoperative atelectasis and terminal bronchial pneumonia Date of onset Sept. 1, 1937

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

25 W
 Other contributory causes of importance: Appendicitis, bilateral salpingitis

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

Name of operation Appendectomy Date of Sept. 1, 1937
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

MOTHER FATHER 13. NAME Homer Guard

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

MOTHER 15. MAIDEN NAME Winnie Neece

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

17. INFORMANT Harold Lester (ADDRESS) Lexington Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lexington Mo DATE Sept 7 1937

19. UNDERTAKER Mrs. C. Foster (ADDRESS) Keokuk

20. FILED Sept 6 1937 M. M. Browne Registrar.

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) J. A. Robertson, M. D.
 (Address) Wesley Hospital, Keokuk, Mo.

EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

JUL 23 1945

**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 Jackson Registration District No. _____ File No. _____
Township Kaw Primary Registration District No. _____ Registered No. 3624
City St. Joe (No. Wesley Hospital) 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

MEDICAL CERTIFICATE OF DEATH

3. SEX ♂ 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR
DIVERCED (write the word) married

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.
20

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 Sept 6 1937 M. A. Brown
Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 6 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 _____ stated above, at _____ m.

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

Date of onset

POST-MORTEM
The contributory causes of importance:
Appendicitis & Salpingitis
Concomitant

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) J. Robinson _____, M. D.
(Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

5-33189