

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

OCT 21 1937

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

Do not use this space.

1. PLACE OF DEATH

County Livingston, Registration District No. 528
Township Chillicothe, Primary Registration District No. 326
City Chillicothe, (No. _____) St. _____ Ward _____

File No. 34678
Registered No. 129

2. FULL NAME Jessye Mae Huff,

(a) Residence, No. _____ St. _____ Ward. Braymer, Mo.
(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 White, 5. ~~Single~~ MARRIED, ~~Widowed~~, OR ~~Divorced~~ (write the word) Married,

5A. IF MARRIED, ~~husband~~ OF _____ (OR) WIFE OF Olin Huff,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-14-1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 27 5 13

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife,
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. House Keeping,
10. Date deceased last worked at this occupation (month and year) August-1-1937 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Kingston, (STATE OR COUNTRY) Missouri.

MOTHER FATHER
13. NAME Clithro C. Lake,

14. BIRTHPLACE (CITY OR TOWN) Kingston, (STATE OR COUNTRY) Missouri.

MOTHER FATHER
15. MAIDEN NAME Bessie Carroll,

16. BIRTHPLACE (CITY OR TOWN) Kingston, (STATE OR COUNTRY) Missouri.

17. INFORMANT Olin Huff, (ADDRESS) Braymer, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Braymer Evergreen Sept. -25-37

19. UNDERTAKER E. P. Michael, (ADDRESS) Braymer, Mo.

20. FILED Sept. 22, 1937 Ronald M. Howell, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 22, 1937

22. I HEREBY CERTIFY, that I attended deceased from July 17, 1937, to Sept. 22, 1937

I last saw her alive on Sept. 20, 1937. Death is said to have occurred on the date stated above, at 3:30 a.m.

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

Suppurative pneumonia
of pyogenic origin

Date of onset

Other contributory causes of importance:

Blow Abscess
Intestinal Obstruction

Name of operation Hepatic Drainage 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?
If so, specify _____

(Signed) Donald M. Lowell M. D.
(Address) Chillicothe, Mo.

139B

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

34678

Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 308

(b) Township Chillicothe Primary Registration District No. 3026

(c) City Chillicothe (d) Street No. _____ Registered No. _____

(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 Jessye Mae Huff

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
	<u>27</u>	<u>5</u>	<u>13</u>	

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 _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22 1932

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:

Hypostatic Pneumonia
Trigocanditi

Date of onset _____

Other contributory causes of importance:

Believe excess
Source unknown
Non purulent

Name of operation Operatory - Drainage 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) Donald M. Dowell, M. D.
(Address) Chillicothe Mo

SUPPLEMENTARY

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

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Local Registrar

5-34678