NOV 16 1937

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

Do not use this space.

1. PLACE OF DEATH
County chariton
Township
City Mendon (No. , St. Ward)

Registration District No. 172
Primary Registration District No. 4101

File No. 37413
Registered No. 7

2. FULL NAME Ida May Solomon

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowdeed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 16th 1872

7. AGE: YEARS 65 | MONTHS 8 | DAYS 24 | If LESS than 1 day, hrs. or min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charitonv county Missouri

FATHER
13. NAME Joseph Oliver
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Lila Cupp
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Robert Sportsman Marceline R.F.D.1

18. BURIAL, CREMATION, OR REMOVAL
PLACE Stanley Cemetery DATE 10-12, 1937

19. UNDERTAKER (ADDRESS) James McLaughlin Marceline

20. FILED Oct. 11, 1937 W. D. West Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct, 10, 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct, 4th, 1937, to Oct, 10th 1937
I last saw her alive on Oct 10, 1937. Death is said to have occurred on the date stated above, at 12-30P.M.
The principal cause of death and related causes of importance were as follows:

Cholecystitis.
Cerebral Hemorrhage
8 3/4

Date of onset 10-4-37

Other contributory causes of importance:
Paralysis of 4 years standing, of the left side.

Name of operation Date of
What test confirmed diagnosis? 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) W. D. West, M. D.
(Address) Mendon, Mo.

...may be properly classified. Exact statement of OCCUPATION is very important.

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FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

37413
Do not use this space.

1. PLACE OF DEATH
(a) County Chariton Registration District No. 172
(b) Township Primary Registration District No. 4101 Registered No. 7
(c) City Mendon (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 Ida May Solomon
(a) Residence, No. ____ St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
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.
60	8	24	

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 Dec 21, 1937 W D West
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 10, 1937

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:

	Date of onset
Cholecystitis	
Cerebral hemorrhage	
SDA	

Other contributory causes of importance:
Paralysis of a four year standing, of the left side

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) W. D. West, M. D.
(Address) Mendon 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.