

DEC 20 1937

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

Do not use this space.

40266

1. PLACE OF DEATH
County Jackson Registration District No. 395
Township Kaw Primary Registration District No. 1002
City Kansas City (No. Mercy Hospital) St. Mo Ward Breckenridge Mo

2. FULL NAME Acie Lee Catron
(a) Residence, No. Breckenridge, Mo St. Mo Ward Breckenridge 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14 - 1937

7. AGE YEARS MONTHS DYS If LESS than 1 day, hrs. or min.
4 mos 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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) Breckenridge, Mo.

13. NAME Acie Catron

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

15. MAIDEN NAME Corea Reburn

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

17. INFORMANT (ADDRESS) Acie Catron
Breckenridge Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Posit Hill Breckenridge Mo DATE Nov 16 1937

19. UNDERTAKER (ADDRESS) H. McBurn & Son
Breckenridge Mo.

20. FILED Nov 14 1937 M. M. - Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-14-1937

22. I HEREBY CERTIFY, That I attended deceased from 11-11-1937, to 11-14-1937

I last saw h.w. alive on 11-14-1937 Death is said to have occurred on the date stated above, at 4:40 p.m.

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

Pneumonia
107a

Other contributory causes of importance:

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?.....

If so, specify.....

(Signed) C. J. Eldridge, M. D.
(Address) Mercy Hospital
W. V. Silvers

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

40266

Do not use this space.

1. PLACE OF DEATH

- (a) County Jackson Registration District No. 399
 (b) Township _____ Primary Registration District No. 1002 Registered No. 4580
 (c) City Kansas City (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 Acie Lee Catron

- (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8
(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.
4

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

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-14 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:

Brachio Pneumonia Date of onset

Other contributory causes of importance: nas.

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) C. J. Eldridge, M. D.

(Address) Mersey Hoop Co

SUPPLEMENTARY

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

AGE should be stated EXACTLY. PHYSICIANS SIGNATURE should be classified. Exact statement of OCCUPATION is very important.

N. H. CAU

**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 Registration District No.
Township Primary Registration District No.
City (No. *1*) *Mercy Hospital*

File No.
Registered No. *4580*
St. Ward)

2. FULL NAME

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 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) *July 4 - 1937*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 10

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) *Buckneridge mo*

13. NAME *Alice Catron*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*

15. MAIDEN NAME *Corea Robinson*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Buckneridge mo*

17. INFORMANT (ADDRESS) *Alice Catron Buckneridge mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Buckneridge mo* DATE *Nov 16 37*

19. UNDERTAKER *T. J. McPeak & Son* (ADDRESS) *Buckneridge mo*

20. FILED *Nov 4 1937 M. M. Croome* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11/4 1937*

22. I HEREBY CERTIFY, That I attended deceased from to

Last saw him alive on, 19..... Death is said

to have occurred on the date listed above, at.....m.

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

Date of onset

Other contributory causes of importance:

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), M. D.

(Address)

N. 1. - Every item of information should be carefully supplied. A statement of OCCUPATION should be given in plain terms, so that it may be understood. REGIS

SUPPLEMENTARY