

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

3054
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408
 (b) Township _____ Primary Registration District No. 3020 Registered No. _____
 (c) City Carthage (d) Street No. McCune-Brooks Hospital 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 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Urmina Fly
 (a) Residence, No. 2014 Garrison Ave. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. J. Fly
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 21, 1867
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
70 0 16
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6, 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1938, to Jan 6, 1938
 I last saw her alive on Jan 6, 1938. Death is said to have occurred on the date stated above, at 2:15pm
 The principal cause of death and related causes of importance were as follows:

Septic Infection of throat streptococci Date of onset Jan 1, 1938

Other contributory causes of importance:

Name of operation none Date of _____
 What test confirmed diagnosis? Lab Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) H. A. Limes _____, M. D.

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

FATHER 13. NAME Gabriel Bible

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

MOTHER 15. MAIDEN NAME Amanda Langbran

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

17. INFORMANT (ADDRESS) Mrs. J. O. Goosetree
Carthage, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Park Cemetery DATE Jan. 8, 1938

19. FUNERAL DIRECTOR (ADDRESS) Ulmer Funeral Home
Carthage, Missouri

20. FILED Jan 8, 1938 W. M. Howard Local Registrar. 370 (Address) Carthage Mo

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.

RECEIVED

FEB 25 1938

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MO. STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, Ed C. Ulmer, Licensed Embalmer No. 2222

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed

Ed C. Ulmer

Licensed Embalmer No. 2222

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)