

3:15 AM.

REC'D MAY 18 1938

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

Do not use this space.

14512

1. PLACE OF DEATH

County Sangras  
Township Campbell  
City Brown Branch (No. ....)

Registration District No. 974  
Primary Registration District No. 5382

File No. ....  
Registered No. 5  
St. .... Ward)

2. FULL NAME Ida M. Mackey

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

Length of residence in city or town where death occurred 57 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, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert Mackey

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 18 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
57 7 22

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) Brown Branch

FATHER 13. NAME George Sherrard

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Sarah Thomas

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

17. INFORMANT Albert Mackey (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Sherrard DATE 4-11 1937

19. UNDERTAKER (ADDRESS) ....

20. FILED 4.12.1938 Worcester Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from August 1936, to April 10 1937

I last saw her alive on April 9 1937 Death is said to have occurred on the date stated above, at 3:15 PM.

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

Chronic indigestion  
Other contributory causes of importance: 118 C.F.  
Date of onset

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 J. C. Ellis (Signed) ....., M. D.

(Address) Rose .....

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.

off Oct  
Rm

OFFICE OF THE ATTORNEY GENERAL  
STATE OF TEXAS  
AUGUST 1964

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

145-12  
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas Registration District No. 974  
 (b) Township Campbell Primary Registration District No. 5382 Registered No. ....  
 (c) 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 Ida m machey

(a) Residence, No. .... St. 7  
 (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 7 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.  
37 7 22

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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) apr 10 1938

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:

chronic indigestion  
 Date of onset  
 Other contributory causes of importance: 1150

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. C. Ellis, M. D.  
 (Address) Rome, mo.

SUPPLEMENTARY Cause

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

