

REC'D MAY 6 1938

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

Do not use this space.

1. PLACE OF DEATH

County *Sullivan*
Township *Lowman*
City *Argood* (No. *000*)

Registration District No. _____
Primary Registration District No. *851*
4520

File No. *16053*
Registered No. _____
St. _____ Ward _____

2. FULL NAME *Miss Olive May*

(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*) *Wid.*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *J. E. May*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 16 1851*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 5 11

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) *Sull. Co. Mo.*13. NAME *Rubin Kalbits*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*15. MAIDEN NAME *Malinda Johnson*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*17. INFORMANT *Mrs O. D. Williams*
(ADDRESS) *Lawrence Mo*18. BURIAL, CREMATION, OR REMOVAL PLACE *Campground Cem.* DATE *Mar 1, 1938*19. UNDERTAKER *Robbey & Son*
(ADDRESS) *Galt Mo*20. FILED *May 1st 1938* *Cordelia Shores* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 27 1938*22. I HEREBY CERTIFY, That I attended deceased from *Feb 8 1938*, to *Feb 27 1938*I last saw her alive on *Feb 25 1938*. Death is saidto have occurred on the date stated above, at *9 P.* m.

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

Pneumonia 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) *U. S. Bradley* M. D.(Address) *Haris, Mo.*

770

104-

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

16053
Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 657
 (b) Township..... Primary Registration District No. 45-20 Registered No.....
 (c) City Osgood (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 Olive May

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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.
86 5 11
 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. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1938
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw him..... 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:
Pneumonia
bronchial
 Other contributory causes of importance:
1070
 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) U. S. Bradley, M. D.
 (Address) Farrus Jos

BY MAIL WILL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

S-16053 1938