

REC'D JUN 10 1938

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

Do not use this space.

## 1. PLACE OF DEATH

County *Greene*Township *Board*

City

Registration District No. *325*Primary Registration District No. *245-1*File No. *18311*

Registered No.

St.

Ward)

2. FULL NAME *Paris Etta Lindsey 532*(a) Residence, No. *Willard R 2*

(Usual place of abode)

St. *Ward.*

(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 *Single*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *October, 28-1919*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .....hra. or .....min.

*18**6**26*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

*Student.*

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 *0*12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Greene County Missouri*

MOTHER FATHER

13. NAME *Gamon Hubert Lindsey*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Greene County Missouri*15. MAIDEN NAME *Hattie Noble*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Greene County Missouri*17. INFORMANT (ADDRESS) *W. Hubert Lindsey*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Rose Hill*DATE *May-1938*19. UNDERTAKER (ADDRESS) *Param General Home Ash Grove, Mo.*20. FILED *June 5 1938**Etta B. McCalister*

Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May-28 1938*22. I HEREBY CERTIFY, That I attended deceased from *June 1937*, to *May-21-1938*I last saw her alive on *May 21 1938*. Death is saidto have occurred on the date stated above, at *31* m.

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

*Cerebral Tumor.*

Date of onset

Other contributory causes of importance:

Name of operation *none* Date of *nd*What test confirmed diagnosis? *Clinical* 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) *Charles H. McHaffie!*, M. D.(Address) *Ash Grove, Mo.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

557

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

18311  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 325  
 (b) Township Cass Primary Registration District No. 3457 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 Doris Etha Lindsey

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25 1938

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

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:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
18 6 26

Cerebral Tumor  
Benign growth.

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 \_\_\_\_\_

Other contributory causes of importance: SHJ

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 7-13- 1938 Chas H McHaffie Local Registrar

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) Charles H McHaffie, M. D.  
 (Address) 1001 Grand

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

