

1938

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

43673
Do not use this space.

1. PLACE OF DEATH *Linu 2*

(a) County *Linu* Registration District No. *496*

(b) Township *Brookfield* Primary Registration District No. *3075* Registered No. *96*

(c) City *Brookfield* (d) Street No. *Mc Barney Hospital* St.

(e) Length of residence in city or town where death occurred *24* yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Rosa Albertina Cuddy*

(a) Residence, No. *401 S. Monroe* St. (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*) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 1-1885*

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

53 4 29

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. *At Home*

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) *Creston* (STATE OR COUNTRY) *Iowa*

FATHER 13. NAME *Gustavus Backstrom*

14. BIRTHPLACE (CITY OR TOWN) *Sweden* (STATE OR COUNTRY) *7*

MOTHER 15. MAIDEN NAME *Mary Katherine Selander*

16. BIRTHPLACE (CITY OR TOWN) *Sweden* (STATE OR COUNTRY) *7*

17. INFORMANT (ADDRESS) *John A Backstrom Brookfield Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Rose Hill - Brookfield Jan 1 1929*

19. FUNERAL DIRECTOR (NAME) *Hills Chapel* (ADDRESS) *Brookfield*

20. FILED *Jan 1 29* *Spottiswood* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 30 1938*

22. I HEREBY CERTIFY, That I attended deceased from *17/1 1938* to *12/30 1938*

I last saw her alive on *12/30 1938* Death is said to have occurred on the date stated above, at *11:10 a.m.*

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

Other contributory causes of importance:

Acute Myocarditis 8 hrs.

Name of operation *None* Date of *0*

What test confirmed diagnosis? *Ch. Hcl* 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 *0*, 19*00*

Where did injury occur? *0* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *0*

Nature of injury *0*

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify *0*

(Signed) *J. M. Zany*, M. D.

(Address) *Brookfield, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
 (a) County Linn Registration District No.
 (b) Township Primary Registration District No. Registered No.
 (c) City Brookfield (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 Rosa A Cuddy
 (a) Residence, No. (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 (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.
	<u>53</u>	<u>4</u>	<u>29</u>	

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
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-30, 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:
acute Myo Carditis Date of onset 9/3/38
 Other contributory causes of importance Chronic infected Gall Bladder (Cholecystitis)

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) Jno J McKeyney, M. D.
 (Address) Brookfield

SUPPLEMENTARY

Local Registrar.

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

