

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

35507
Do not use this space.

NOV 20 1939

1. PLACE OF DEATH
(a) County Buchanan 3 Registration District No. 85
(b) Township St. Joseph 2 Primary Registration District No. 100 Registered No. 1021
(c) City St. Joseph (d) Street No. State Hospital #2 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 Mary Frances Ligon
(a) Residence, No. Keansy Mo. St. Keansy Mo.
(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 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 W.B. Ligon
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 25, 1857
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 5 12
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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keansy Kentucky
13. NAME Jacob Allfree
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Burnsylvanian
15. MAIDEN NAME Jane Brown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
17. INFORMANT St. Hosp. #2 records
(ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE Keansy Mo. DATE 10/9 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) C.H. Blackman
Keansy Mo.
20. FILED Oct 7 1939 H.J. Kelliback Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 7 1939
22. I HEREBY CERTIFY, That I attended deceased from Dec 22 1936, to Oct 7 1939
I last saw her alive on 10-7 1939. Death is said to have occurred on the date stated above, at 12:30 P.M.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
Cardio-vascular
Date of onset 10-6-39
Other contributory causes of importance:
Cardio-vascular Hypertension
Name of operation _____ Date of _____
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? No.
If so, specify _____
(Signed) Donald H. Breit M. D.
(Address) St. Hosp. #2

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
V. S. NO. 2. 50M-9-19-38 I X16005

N. R.—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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.