

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

Do not use this space.

1046

**1. PLACE OF DEATH**

County Hennepin

Registration District No. 349

Township Calhoun

Primary Registration District No. 4207

City Calhoun (No. \_\_\_\_\_)

File No. \_\_\_\_\_

Registered No. 7

St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(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 27 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 A. B. Green

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May, 16, 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	74	7	19	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia?

10. NAME OF FATHER Jacob Gray

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Kirkpatrick

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

14. INFORMANT Miss Olive Green (Address) Calhoun

15. FILED 1/28, 19 Miss A. A. Gray REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Jan 5, 1931, and that I last saw her alive on Jan 5, 1931; and that death occurred, on the date stated above, at 4, 12, m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

CONTRIBUTORY (SECONDARY) Chronic Valvular Disease of the Heart (duration) 1 yrs. 6 mos. - ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) S. A. Ballard, M. D.  
, 19 (Address) Calhoun

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

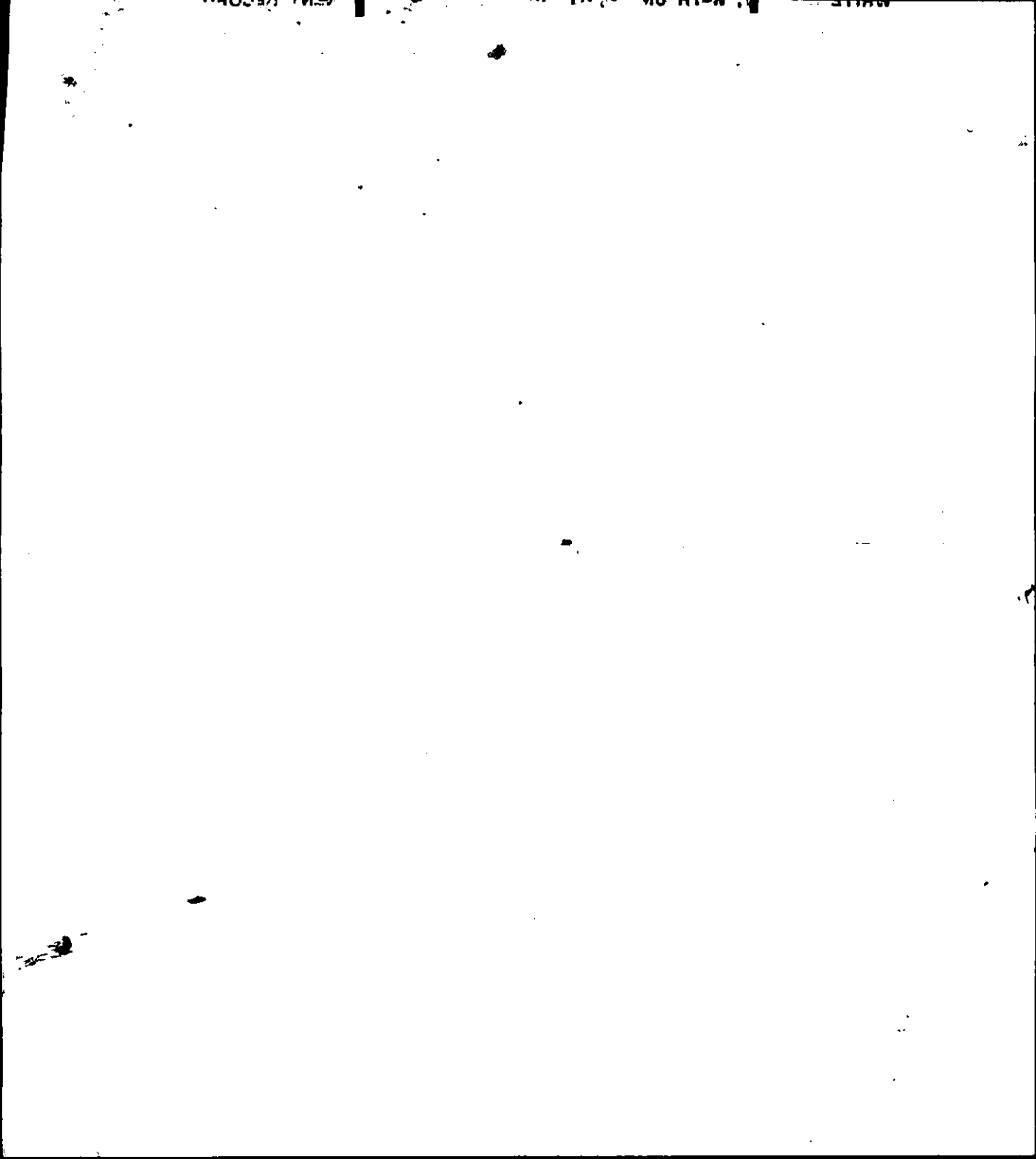
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calhoun Cemetery DATE OF BURIAL Jan 6 1931

20. UNDERTAKER J. A. Housey ADDRESS Calhoun

WRITE COMPLETELY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Henry Registration District No. 349 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4207 Registered No. 7  
 City Calhoun (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 F 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. \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT (Address) \_\_\_\_\_

15.

FILED 1/28, 1931 Mrs. A. G. Gray REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Lobar  
108  
 (duration) yrs. mos. ds. \_\_\_\_\_  
 CONTRIBUTORY (SECONDARY) Chronic Valvular  
Disease of the heart  
 (duration) yrs. mos. ds. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calhoun Cemetery 1/6 1931

20. UNDERTAKER

ADDRESS

J. A. Souney Calhoun Mo.

SUPPLEMENTARY

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

WHITE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

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