LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

13

21084-d

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

1. PLACE OF DEATH
County Dallas — Registration District No. 241 — File No. 21084
Township South Benton — Primary Registration District No. 5334 — Registered No.
City ..... (No. ..... St. ..... W

2. FULL NAME Eva Margret Montgomery
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 7 1863

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
57	11	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Agent & housework
(b) General nature of industry, business, or establishment in which employed (or employer): selling merchandise
(c) Name of employer: Larkin Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo. Dallas Co

PARENTS

10. NAME OF FATHER: Thos. Benton Montgomery
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Augustine Edwards
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Effie M. Stanley
(Address): Buffalo Mo

15. FILED 8/27, 1923 — V. A. Asbridge, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/24

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924 to July 14, 1924 that I last saw her alive on July 14, 1924 death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Stomach
(duration) ..... yrs. ..... mos.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos.

44

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) B. F. Johnson, 19 (Address) Buffalo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Buffalo Mo — DATE OF BURIAL: 7/25

20. UNDERTAKER: Jack Newport — ADDRESS: Buffalo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, 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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PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

h 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

X | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

TE OF BIRTH (MONTH, DAY AND YEAR)

E | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

CUPATION OF DECEASED

) Trade, profession, or
articular kind of work .....

) General nature of industry,
usiness, or establishment in
hich employed (or employer).....

) Name of employer

THPLACE (CITY OR TOWN) .....
TATE OR COUNTRY)

NAME OF FATHER

BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

ORMANT .....
dress)

ED..... 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS