OCT 24 1927

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

Do not use this space.

1 26491

1. PLACE OF DEATH
County BUCHANAN — Registration District No. 85
Township ~~WASHINGTON~~ — Primary Registration District No. 1001
City ST JOSEPH (No. ..... St. ..... Ward)

File No. ..... Registered No. 890

2. FULL NAME MALINDA A. BRADY
(a) Residence. No. 1522 FARARON St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 70 yrs. # mos. # ds. How long in U.S., if of foreign birth? yrs. mos. ds.

3

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): WIDOW

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: JOHN T BRADY

6. DATE OF BIRTH (MONTH, DAY AND YEAR): JUNE 10TH 1844

7. AGE: YEARS 82 — MONTHS ~~8~~ 2 — DAYS 23 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): FLEMING CO
(STATE OR COUNTRY): KTY

PARENTS
10. NAME OF FATHER: WM TERHOUNE
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): KTY
12. MAIDEN NAME OF MOTHER: MARGARET GOODING
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): KTY

14. INFORMANT: MRS M.T. SMITH
(Address) 1522 FARARON STR-CITY

15. FILED SEP 5 1927 — John G. Utz, S.S. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): SEPT 3RD 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1927, to Sept 3, 1927, that I last saw her alive on Sept 2, 1927, and that death occurred, on the date stated above, at 3:A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia (Chronic)
135B
132B
162 (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY): Chronic cystitis & senility (duration) 5 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & microscopic
(Signed) J. F. Owens, M.D.
SEPT 3RD 1927 (Address) Schneider Bldg. - City

*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: ASHLAND CEMETERY — DATE OF BURIAL: SEPT 5 1927

20. UNDERTAKER: Rock Funeral Home - 906 Sylvanie — ADDRESS
BY - J.A. MOLES (MGR.)

CAUSE OF DEATH ... AGE should be stated EXACTLY. PHYSICIANS should state ... may be properly classified. Exact statement of OCCUPATION is very important.

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 Buchanan — Registration District No. 85 — File No.
Township Washington — Primary Registration District No. 1001 — Registered No. 890
City ..... St. ..... Ward)

2. FULL NAME Malinda A. Brady
(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): wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 - 1844

7. AGE: 83 YEARS — MONTHS: 2 — DAYS: 23 — 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)

PARENTS
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 11/9 1927 John Gretz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1927

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

SUPPLEMENTARY

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

CAUTION: [illegible] item of information should be carefully [illegible] supplied. AGE [illegible] stated EXACTLY. PHYSICIANS should state properly classified. [illegible] statement of OCCUPATION is very important.

5-9-91