

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

Do not use this space.

1. PLACE OF DEATH

County Stoddard Registration District No. 840
 Township Neutral Creek Primary Registration District No. 6102
 City (No. _____) St. _____ Ward _____

File No. 29306
 Registered No. 42

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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-2 1927

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

17. I HEREBY CERTIFY That I attended deceased from 9-2 to 9-2, 1927, that I last saw her alive on 8-22, 1927, and that death occurred, on the date stated above, at 30 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
82 3 20

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Senile Debility associated with arteriosclerosis
 (duration) _____ yrs. _____ mos. _____ da.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housekeeper 97
 (b) General nature of industry, business, or establishment in which employed (or employer) 162
 (c) Name of employer _____

CONTRIBUTORY (SECONDARY) NID
 (duration) _____ yrs. _____ mos. _____ da.

9. BIRTHPLACE (CITY OR TOWN) Ill
 (STATE OR COUNTRY)

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

10. NAME OF FATHER John Huff

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

20. WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Mary Buckner

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. M. Page M. D.
9-3 1927 (Address) Cape's Mr.

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

*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.

14. INFORMANT (Address) J. H. Wilson
Cape's Mr.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Rock Point Cemetery 9-4 1927

15. Sept 2 1927 O L Hope
 REGISTRAR

20. UNDERTAKER ADDRESS
Wickman White Cape's Mr.

CAUSE OF DEATH to be plainly stated, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. Cause of death to be plainly stated, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1. PLACE OF DEATH

County Hodgdon Registration District No. 840
Township Suck Creek Primary Registration District No. 6102
City (No.) St. Ward)

File No.
Registered No. 47

2. FULL NAME

Mary A Creager
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A Creager
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 11-1948
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
79 | 3 | 21 | 0 | 0 | 0
8. OCCUPATION OF DECEASED (Completed age)
(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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1927
17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to Sept 2, 1927, that I last saw her alive on Aug 22, 1927, and that death occurred, on the date stated above, at 110 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Senescibility
Associated with
Arteriosclerosis
(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) J M Page, M. D.
Sept 2, 1927 (Address) Quincy Mo

*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.

9. BIRTHPLACE (CITY OR TOWN) Ill
(STATE OR COUNTRY)

10. NAME OF FATHER John Hull

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

12. MAIDEN NAME OF MOTHER Mary Bushne

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

14. INFORMANT J L Wilson
(Address) Quincy Mo

15. Sept 2 1927 E L Hope
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Rock Point Cemetery DATE OF BURIAL Sept 4 1927

20. UNDERTAKER Hickman Phil Store Co ADDRESS Quincy Mo

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

S-29306