22 1928
1928

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

Do not use this space.

4375

1. PLACE OF DEATH
County Clay & Liberty
Township [illegible]
City Maple Park (No. ..... St. ..... Ward)
Registration District No. 201
Primary Registration District No. 5280
File No. .....
Registered No. 13

2. FULL NAME Ruth Celestina Devers
(a) Residence. No. ..... Maple Park Mo 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 29-1853

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
74	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife 126 124
(b) General nature of industry, business, or establishment in which employed (or employer) 127
(c) Name of employer

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

PARENTS
10. NAME OF FATHER John Ledbetter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill
12. MAIDEN NAME OF MOTHER Elizabeth Wright
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT Mrs. A. B. Cleveland
(Address) Maple Park

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby 7 - 1928

17. I HEREBY CERTIFY, That I attended deceased from About One year, to ....., 19.....
that I last saw her alive on Feb 7, 1928, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis of Liver and Stone obstructing Common duct
123 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Peritonitis from rupture of bile duct (duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Wm H Goodson, M. D
2/8/28, 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 Cave-in Rock Ill
DATE OF BURIAL 2/11/ 1928

20. UNDERTAKER Church - Archer Co
ADDRESS Liberty Mo

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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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH

County: Clay Registration District No.: 201 File No.:

Township: Liberty Primary Registration District No.: 5280 Registered No.:

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

2. FULL NAME: Ruth Celestinia Devers

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W.	S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 29 - 1853.

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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 3/10/28 Wm H Goodson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 7 1928

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(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

(duration) yrs. mos. ds.

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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)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY