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

Do not use this space.

7671

1. PLACE OF DEATH

County: Ausbrain — Registration District No.: 26 — File No.:

Township: Gathman — Primary Registration District No.: 3002 — Registered No.: 44

City: Mexico (No. 405 Northwestern ave St. Ward)

2. FULL NAME Mable Hellen Pasley

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

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)
female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-14-1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	5	10	

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

9. BIRTHPLACE (CITY OR TOWN) Mexico
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER James Lovell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mexico
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Rebecca Allison
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs Cleo Pasley
(Address) Meyer Mo

15. FILED March 24 1928 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24 1928

17. I HEREBY CERTIFY, That I attended deceased from March 17, 1928, to March 24, 1928, that I last saw h. alive on March 24, 1928, and that death occurred, on the date stated above, at 3 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
due to Septicemia

1 hr (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
1 hr (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF March 17-28
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) Pable E. Coal, M. D.
, 19 (Address) Mexico 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Meyer Mo Cem — DATE OF BURIAL: 3-25-1928

20. UNDERTAKER: H. A. Breckt Undertaker — ADDRESS: Meyer 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: Audrain — Registration District No.: 26 — File No.:
Township: — Primary Registration District No.: 3002 — Registered No.: 44
City: Mexico (No. ..... St. ..... Ward)

2. FULL NAME: Mable Hellen Pasley

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

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)

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 March 24th 1928. Ira S. Milligan, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 24 1928

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:
Peritonitis due from Septicemia. Due to abortion performed about 10 days previous
(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.

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

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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