

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

Do not use this space.

8142

1. PLACE OF DEATH

County Cape Girardeau
Township Union
City St. Hill

Registration District No. 137
Primary Registration District No. 4877

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

Minnie May Mounts

(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)

married

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

C. L. Mounts

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

July 8 - 1873

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>54</u>	<u>9</u>	<u>23</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Sullivan Co

(STATE OR COUNTRY)

10. NAME OF FATHER

Frank

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

12. MAIDEN NAME OF MOTHER

Margaret Yorkum

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14. INFORMANT

C. L. Mounts
(Address) St. Hill Mo

15. FILED

3-4, 1925 W. Kemp
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1928, to Mar 1, 1928 that I last saw her alive on Mar 1, 1928, and that death occurred, on the date stated above, at 11:25 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
BRA
876
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Nervous Breakdown
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAICTED 7401
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Charles Orr, M. D.
, 19 (Address) St. Hill 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

DATE OF BURIAL

St. Hill Cemetery Mar 4 1928

20. UNDERTAKER

ADDRESS

Grant E. Slater St. Hill Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

