

7 2 5 1928
 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.

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

Do not use this space.

26824

1. PLACE OF DEATH
 County Osage Registration District No. 215
 Township Jefferson Primary Registration District No. 3014
 City Jefferson (No.) (St.) (Ward)

2. FULL NAME Emma Gleason Whitson
 (a) Residence No. 823 E High 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

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 J. O. Whitson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 5
 7. AGE YEARS MONTHS DAYS
47 6 9 If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) at home
 (c) Name of employer higher

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14 1928
 17. I HEREBY CERTIFY That I attended deceased from 7/31 1928 to 8/14 1928
 that I last saw her alive on 8-13 1928 and that death occurred, on the date stated above, at 145 St.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral thrombosis
 CONTRIBUTORY (SECONDARY) 74 B
 (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) higher
 (STATE OR COUNTRY) mo
 10. NAME OF FATHER Jas. Murre
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Scotland
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Margaret Wilson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scotland
 (STATE OR COUNTRY)
 14. INFORMANT Mrs. J. G. Murre
 (Address) higher mo
 15. FILED 9-5-28 J. W. Berford REGISTRAR

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 8. DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Edward Keld M. D.
8/14 1928 (Address) Jefferson Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Roberts Ave
 DATE OF BURIAL 8/16 28
 20. UNDERTAKER Lawson-Tanna
 ADDRESS J. C. M.



**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 Bole Registration District No. 213 File No.
 Township J. City Primary Registration District No. 3114 Registered No. 107
 City (No.) St. Ward)

2. FULL NAME

Emma G. Whitmore

(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 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) Feb 3 - 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 6 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

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 10/13-28 L. B. Beardford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14 19 28

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:

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

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SUPPLEMENTARY

5-26824