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

Do not use this space.

1186

1929 39 0 0

**1. PLACE OF DEATH**

County: Green — Registration District No.: 320 — File No.:

Township: Center — Primary Registration District No.: 5 — Registered No.:

City: — (No. ..... St. ..... Ward)

**2. FULL NAME** Mary Jane Claypool

(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 1 yrs. — mos. — ds. How long in U.S., if of foreign birth? 77 yrs. 2 mos. 14 ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Fem
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): ✓

7. AGE: Years 77 | Months 2 | Days 14 | If LESS than 1 day, — hrs. or — min.

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

9. BIRTHPLACE (CITY OR TOWN): Pearl Mo
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: JW Lowery
11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): Tennessee
12. MAIDEN NAME OF MOTHER: Harriet Peck
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): Missouri

14. INFORMANT: Mrs. M. Scroggs
(Address): R.D. Elwood

15. FILED 4/1, 1929. Lucy Hoyal, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1 — 4 — 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-29-, 1928, to 1-4-, 1929, that I last saw her alive on 1-3-, 1929, and that death occurred, on the date stated above, at 1:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Bronchial Pneumonia

110 111

162 (duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (SECONDARY): Senility + Influenza

(duration) — yrs. — mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at POD

DID AN OPERATION PRECEDE DEATH? no. DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Usual Symptoms

(Signed) B. Frank Windle, M.D.

1/4/, 1929 (Address) Bois D'Arc 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~~: Prospect Cem — DATE OF BURIAL: 1/5/ 1929

20. UNDERTAKER: Redfearn + Hoyal — ADDRESS: Bois D'Arc

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

...IMMANENT RECORD

# 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: Greene — Registration District No.: 320 — File No.:

Township: Center — Primary Registration District No.: 5443 — Registered No.:

City: (No. , St. Ward)

2. FULL NAME: Mary Jane Clay Pool

(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) |
|---|---|---|
| F | W. | W. |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1857-11-20

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 77 | 2 | 14 | |

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 1-5-1929 Lucy E. Hoyal
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 4 1929

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:

(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

N. B.—Every ... of information should be carefully supplied. A CAUSE OF D... TH in plain terms, so that it may be properly classifi...

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

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