

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

Do not use this space.

7069

**1. PLACE OF DEATH**

County Lafayette

Registration District No. 464

File No. 13

Township \_\_\_\_\_

Primary Registration District No. State

Registered No. 7

City Mayview, Mo. (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ (Ward \_\_\_\_\_)

**Pearl May Hofmann Clouse**

**2. FULL NAME**

(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**

2. 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 Archie Clouse

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 19th 1901

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>28</u>	<u>1</u>	<u>8</u>	<u>27</u>	

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Lafayette Co. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Frank Hufman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mrs. Emma Currier

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Sad Clouse  
(Address) Mayview Mo

15. Man 10 29 W. Crooley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 13 1929 to Feb 13 1929 that I last saw h. lx alive on Feb 13 1929, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Peritonitis

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? None

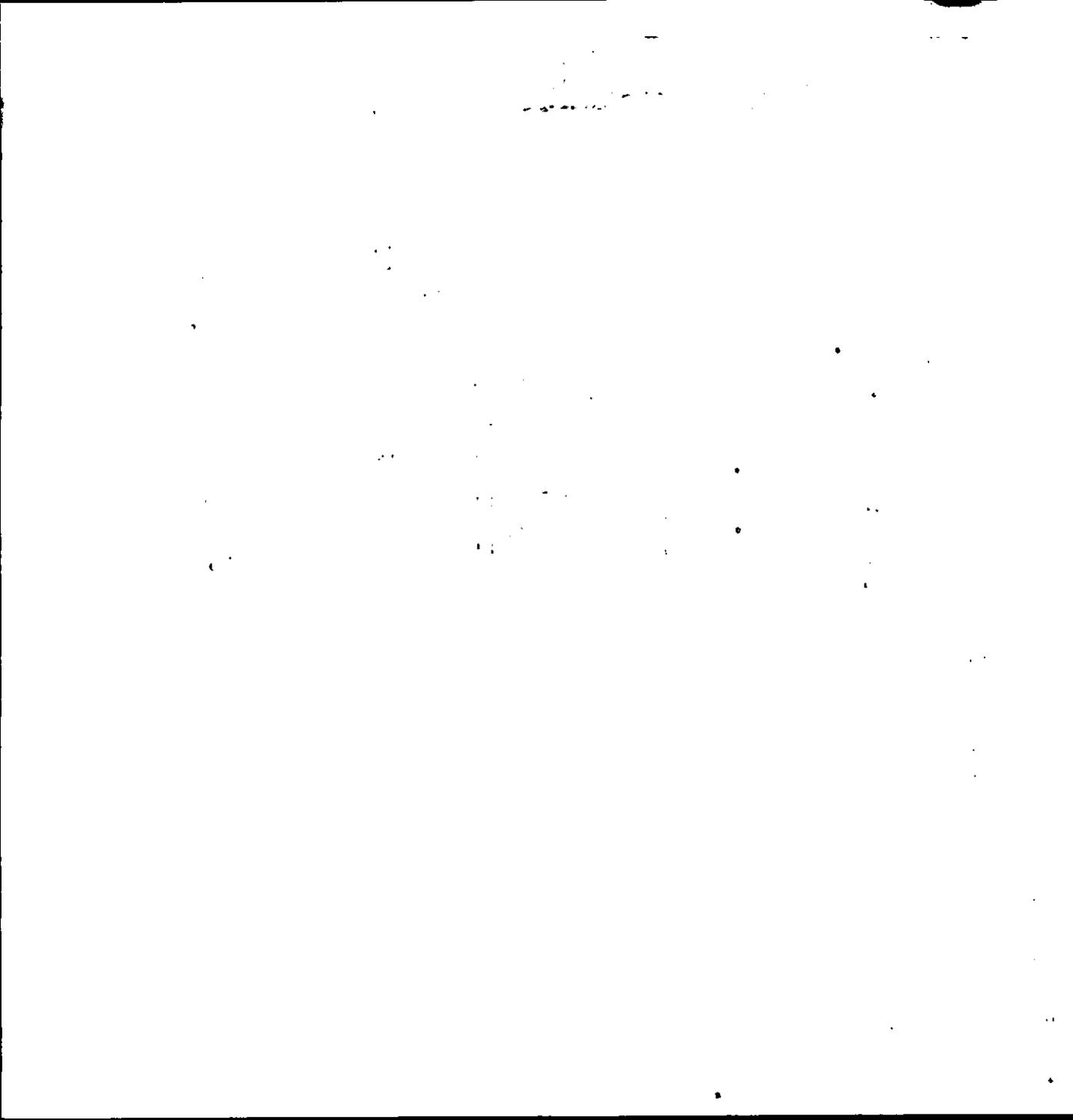
(Signed) Joseph J. Williams, M. D.

Address 2/15, 1929 Mayview 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 Zions Hill DATE OF BURIAL 2/15/29

20. UNDERTAKER W. Crooley ADDRESS Higginsville, Mo.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Lizajette Registration District No. 464 File No. 19  
 Township Mayview Primary Registration District No. 4275- Registered No. 7  
 City Mayview (No. ....) St. .... Ward .....

**2. FULL NAME** Deed May H. Clouse

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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) April 19 - 1901

7. AGE YEARS MONTHS DAYS H LESS than 1 day, .... hrs. or .... min.  
27 9 24

**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) .....

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 3/10/21 R. Scholz REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 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:  
Perforated Ulcerative Colitis  
 (duration) .... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) 1140 (duration) .... mos. .... da.

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

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

SUPPLEMENTARY

boots