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

Do not use this space.

9160

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Shannon — Registration District No.: 823

Township: Winona — Primary Registration District No.: 6078

City ..... (No. ....., ..., St. ....., Ward)

2. FULL NAME: Myrtle Lorene Mayberry

(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): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep 15 1924

7. AGE: Years 4 | Months 5 | Days 24 | 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): Winona
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Ben Mayberry

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

12. MAIDEN NAME OF MOTHER: Hattie Barnes

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

14. INFORMANT: Boone Mayberry
(Address): Winona Mo

15. FILED: 2-19-29 Mabel Collins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1929, to Feb 9 1929, that I last saw h.. alive on Feb 7 1929, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Bronchial
10 days
Sep 15

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) abscess of Right ear

(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? .....

Feb 11, 1929 (Signed) L. J. Lehenoweith M. D.
(Address) Winona 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: Mt Zion Cemetery

DATE OF BURIAL: 2-11 1929

20. UNDERTAKER: None

ADDRESS: —

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.