

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

Do not use this space.

9335 ^a

1. PLACE OF DEATH

County Webster

Registration District No. 9.01

Township West Benton

Primary Registration District No. 6.2.09

City (No. _____) _____

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

Mary Tennessee Bestie

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1929 to Feb 21 1929, and that I last saw her alive on Feb 20 1929, and that death occurred, on the date stated above, at _____ m.

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

None Bestie

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Branches Pneumonia
(duration) yrs. mos. 7 ds.

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

May 31 1845

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>83</u>	<u>9</u>	<u>21</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 _____

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER

Andy Galbraith

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) W. A. Atkins M. D.

12. MAIDEN NAME OF MOTHER

Lou Armstrong

Apr 7 1929 (Address) Rogersville 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.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Palmetto Cemetery Feb 24 1929

14. INFORMANT

Mrs. N. J. Piles
(Address) Rogersville Mo

20. UNDERTAKER

ADDRESS

Rogersville Undertakers Rogersville Mo

15. FILED

APR 12 1929 Nellie Atkins

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 Webster
Township W. Benton
City..... (No.) St. Ward)

Registration District No. 901
Primary Registration District No. 6209

File No. 9335-A
Registered No. 3

2. FULL NAME

Mary Tennessee Beatie

(a) Residence. No. St., Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

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

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

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)..... (duration) yrs. mos. ds.
(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) Unknown
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED apr 12 1929 Nellie Atkins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 21 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:

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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT SIGNIFICANT CHANGES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.
H. U. 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.

SUPPLEMENTARY

5-9335A