

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

Do not use this space.

13754

1. PLACE OF DEATH

City... Andram Registration District No. 26 File No. _____
 Township... Andram Primary Registration District No. 3007 Registered No. 54
 City... Mexico Andram Waspitel St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 2 Ralls Co Mo 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OF 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) Unknown

7. AGE About YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 - -

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)
 (c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Andram Co Hospital Record
 (Address) Mexico Mo

15. April 16th 1929 Dr. A. D. Willigan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-15-1929

17. I HEREBY CERTIFY That I attended deceased from 4-2-1929 to 4-15-1929 that I last saw him alive on 4-15-1929, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
apoplexy
 (duration) 57 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fractured hip
 (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Perry, Mo.
 IF NOT AT PLACE OF DEATH...

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

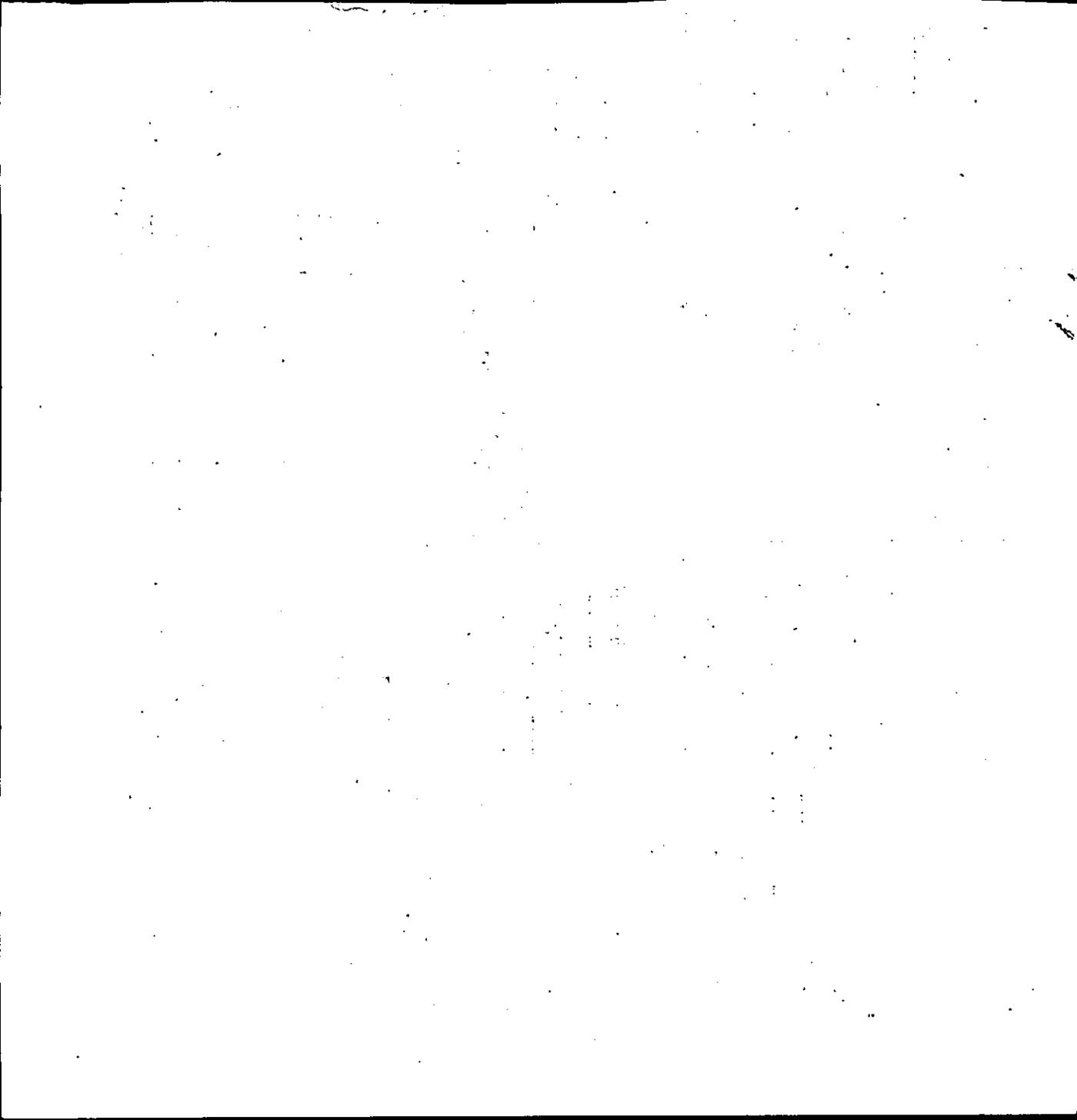
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Frank Jolley, M.D.
4/16 1929 (Address) Mexico, 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 Ralls Co Mo DATE OF BURIAL Not stated 1929

20. UNDERTAKER Roselle & Fry - Perry Mo
 ADDRESS



**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 Anderson

Registration District No. 26

File No. _____

Township _____

Primary Registration District No. 3002

Registered No. 84

City Mexico

(No. _____)

St. _____ Ward _____

2. FULL NAME

Mary L Moore

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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 _____
- (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. April 13, 1929 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13-1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mycobacteriosis Complex
From a fall
CONTRIBUTORY (SECONDARY) Fractured hip
From a Fall

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

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

