

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

Do not use this space.

18967

27 1000  
PLACE OF DEATH

County..... Remick  
Township..... Virginia  
City..... Frankford (No.....)

Registration District No. 655  
Primary Registration District No. 5872

File No.....  
Registered No.....  
St..... Ward.....

2. FULL NAME Marry Clay Bentley  
(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 51 yrs. 5 mos. 12 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) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Frank Bentley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1878

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.  
51 5 12 = min.

**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) Household  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Frankford  
(STATE OR COUNTRY) Remick Co. MO

10. NAME OF FATHER John L. Cornell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Harden Co. Tenn  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER A Senath mayfield

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Harden Co. Tenn  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Cornell  
(Address) Stiles MO

15. FILED 4/18 29 Max Healey  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5: 27 1929

17. I HEREBY CERTIFY, That I attended deceased from 26 May, 1929 to 27 of May, 1929.  
that I last saw her alive on 27 of May, 1929 and that death occurred, on the date stated above, at 125 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

acute yellow atrophy of the liver  
125 A

CONTRIBUTORY (SECONDARY) 120  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: NO

DID AN OPERATION PRECEDE DEATH: NO DATE OF.....  
WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS: biopsy, only  
(Signed) J. R. McFarland, M. D.  
, 19 29 (Address) Stiles 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 C DATE OF BURIAL 5-28 1929

20. UNDERTAKER German and Co ADDRESS Stiles MO

27  
15

116.11

**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 Demiseot  
Township Virginia  
City Virginia (No. ....)

Registration District No. 655-  
Primary Registration District No. 3872

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Mary Clay Gentry

(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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 13 - 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
50 5 12

**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 5/18, 1919 Max P. Kelly REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5 - 27 - 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  
Columbian Cem 19  
20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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