

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

Do not use this space.

21794

1. PLACE OF DEATH

County Jasper
Township Union
City Carthage Mo (No.)

Registration District No. 408
Primary Registration District No. 2020

File No.
Registered No.
St. Ward)

2. FULL NAME Malissie Katherine Straine

(a) Residence No. 1100 Sycamore St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

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 OF (OR) WIFE OF

Albert J. Straine

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>44</u>	<u>5</u>	<u>10</u>		

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) (STATE OR COUNTRY)

Fayette Springs Ark.

10. NAME OF FATHER

James Clark

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

Ark.

12. MAIDEN NAME OF MOTHER

Mandy Woford

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

Towa

14. INFORMANT

Albert J. Straine
(Address) 1100 Sycamore St.

15. FILED

June 24 1929
Carthage
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 20th 1929

17.

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929 to June 20, 1929 that I last saw h. e. s. alive on June 19, 1929, and that death occurred, on the date stated above, at 3:05 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23F
Several years
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

31
(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? Clinical

(Signed) D. X. Cordonnier, M. D.

6/24, 1929 (Address) Carthage 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

DATE OF BURIAL

Park Cemetery 6/24 1929

20. UNDERTAKER

ADDRESS

Whner - Drake Carthage

AGE should be stated in full. Exact statement of OCCUPATION is very important. Properly classified.

25 1929
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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 Jasper
Township Carthage
City Carthage (No. St. Ward)

Registration District No. 408
Primary Registration District No. 3000

File No.
Registered No.

2. FULL NAME

Malissie Katharine Straine

(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 (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-10-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 8 10

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)

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 8/9, 1929 Carl Schauer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 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

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

N. B.—Every item of information should be carefully ascertained and 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. REGISTER—GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-21794