

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

OCT 24 1929 62

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

Do not use this space.

31341

1. PLACE OF DEATH
County Madison Registration District No. 539
Township Big Creek Primary Registration District No. 3728
City..... (No.....) St..... Registered No. 7
Ward.....

2. FULL NAME Hurrietta M. Bruce
(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) Widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12 1866
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
63 - 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(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) Madison Co., Mo.

10. NAME OF FATHER Deeble
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Mary F. Graham
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Madison Co., Mo.

14. INFORMANT Robert Bruce
(Address) Memphis Tenn.

15. Sept 26 1929 M. Carr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 26, 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 26, 1929 that I last saw her alive on Sept 25, 1929, and that death occurred, on the date stated above, at 2:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Infectious
118
1120
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (SECONDARY).....
(duration) yrs. mos. ds.

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.....
(Signed) Adam F. Wagner, M. D.
9-26-1929 (Address) Gravelton, 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 Farmington Cem. DATE OF BURIAL 9-26 1929

20. UNDERTAKER [Signature] ADDRESS 9/24/29

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.

