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

Do not use this space.

39391

File No.

Registered No. 45

1. PLACE OF DEATH

County: Stoddard

Registration District No. 834

Township: ~~[illegible]~~

Primary Registration District No. 4503

City: Advance (No. ..... St. ..... Ward)

2. FULL NAME: Ethel Jane Real

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

4. COLOR OR RACE: W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) X 4/6/25

7. AGE: X 4 Years, 7 Months, 1 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(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): Galma Mo.

PARENTS

10. NAME OF FATHER: Howard Real

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Galma, Mo.

12. MAIDEN NAME OF MOTHER: Cora Day

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Galma, Mo.

14. INFORMANT: John O. Davis
(Address): Advance, Mo.

15. FILED 11-13-1929 N. McKearly, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1929, to Nov. 7, 1929, that I last saw her alive on Nov. 6, 1929 and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngeal diphtheria

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY): 0

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? inspection

(Signed) C. E. Lewis, M. D.

11-13-1929 (Address) Advance, 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: Scotty Cem, Mo. DATE OF BURIAL: 11-8-1929

20. UNDERTAKER: C. O. Biggs ADDRESS: Advance Mo.

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.