MAR 28 1930

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

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

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.

1. PLACE OF DEATH
County: Scotland County — Registration District No.: 1170 — File No.: 6327
Township: — Primary Registration District No.: 6248 H — Registered No.: 35
City: Richmond Hts (No. 7269 Mitchell St. Ward)

2. FULL NAME: Sallie F Bosley
(a) Residence. No. 7269 Mitchell 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): widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Elyah Bosley
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 22 1849
7. AGE: Years 70 Months 11 Days 27 — If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(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): ~~James Lenny~~ Ohio
PARENTS
10. NAME OF FATHER: James Lenny
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: unknown Donnally
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
14. INFORMANT (Address): Mrs. Geo R Smith 7269 Mitchell
15. FILED 2/20, 1930 C. B. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-19 1930
17. I HEREBY CERTIFY, That I attended deceased from 12-25, 1929, to 2-19, 1930 that I last saw her alive on 2-18, 1930, and that death occurred, on the date stated above, at 3 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
94A
107A
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (SECONDARY): Angina Pectoris
(duration) yrs. 6 mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? auscultation
(Signed) Berto Owens, M. D
2/20, 1930 (Address) Mo Bldg

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Park Lawn — DATE OF BURIAL: 2/22 1930
20. UNDERTAKER: A Ellis 5240 Delmar — ADDRESS

235
2

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....St. .....Ward)

2. FULL NAME .....

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

MONTH, DAY AND YEAR)

MONTHS	DAYS	If LESS than 1 day ....hrs. or ....min.

DECEASED

on, 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.
FILED..... 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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

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