

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

Do not use this space.

18389

JUN 28 1930

1. PLACE OF DEATH

County Union Registration District No. 875
 Township Washington Primary Registration District No. 6162
 City (Name) _____ St. _____ Ward _____

File No. _____

Registered No. 115

2. FULL NAME: Makena Andrews

(a) Residence. No. State Hospital #3 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 3, 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 10 5

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) Jackson Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Jas. A. Steele

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

12. MAIDEN NAME OF MOTHER Mary Lowe

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

14. INFORMANT State Hospital #3
 (Address) Neveda Mo.

15. FILED 6/4/30 E. P. King
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28, 1930

17. I HEREBY CERTIFY, That I attended deceased from September 5, 1928, to May 28, 1930
 that I last saw her alive on May 28, 1930, and that death occurred, on the date stated above, at 1:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

196A
197B Ch. Myocarditis
93C
 (duration) 1 yrs. 7 mos. 12 ds.
 CONTRIBUTORY Fracture of neck of the femur
 (SECONDARY) (duration) _____ yrs. _____ mos. 10 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? Clinical

(Signed) K. S. S. Hoff, M. D.
May 28, 1930 (Address) State Hospital #3

*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 _____

Blue Springs Mo 5-29-30

20. UNDERTAKER Myers Funeral Home Neveda
 ADDRESS _____

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.

PARENTS

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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 Jerison Registration District No. 875 File No.
 Township Washington Primary Registration District No. 6162 Registered No. 115
 City (No.) St. Ward)

2. FULL NAME Malena Andrews
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

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

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19..... (that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chf Myocarditis

CONTRIBUTORY (SECONDARY) fracture of neck of femur (duration) yrs. mos. da. accidental fall forward (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? 185
 DID AN OPERATION PRECEDE DEATH? 185 DATE OF
 WAS THERE AN AUTOPSY? 15
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Amstrong, M. D.

7/12, 1930 (Address) Madison # 3
 *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.

14. INFORMANT (Address)

15. FILED 6/4/30 E. R. King REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18389

THE UNIVERSITY OF CHICAGO

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