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

23 1930

1. PLACE OF DEATH

County Montgomery — Registration District No. 938 — File No. 20118

Township Danvill, — Primary Registration District No. 5786 — Registered No.

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

2. FULL NAME Mary J. Brookshier,

(a) Residence. No. New Florence, Mo. RFD 2, ..... 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) |
|---|---|---|
| Female | White | Widowed |

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. |
|---|---|---|---|
| 78 | 6 | 21 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework,

(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) Montgomery Co, Mo.

PARENTS

10. NAME OF FATHER Wm Morrow,

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

12. MAIDEN NAME OF MOTHER Martha J. Rigg,

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

14. INFORMANT [signature]
(Address) New Florence Mo

15. FILED 6/5, 19.. J. E. Gibson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb., 1921, to June 2, 1930 that I last saw her alive on March 16, 1930, and that death occurred, on the date stated above, at 6.30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency with cardiac hypertrophy moderate
928
951
105
(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arterial hypertension
(duration) 10 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? Physical examination

(Signed) Bruce Menefee, M.D

June 2, 1930 (Address) Montgomery City 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 |
|---|---|
| Lone Cemetery | June 3 1930 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| Barton Bake | Cameron Mo |

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

[illegible] CALLED FOR [illegible] ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Montgomery — Registration District No. 938 — File No. .....

Township Danville — Primary Registration District No. 5786 — Registered No. .....

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

**2. FULL NAME** Mary J. Brookshire

(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) |
|---|---|---|
| F | W | W |

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

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

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(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 9/16, 1930 J. E. Gibson
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 1930

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.

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

SUPPLEMENTARY

S-20118