

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

Do not use this space.

16739

**1. PLACE OF DEATH**

County Saline Registration District No. 796 File No. \_\_\_\_\_  
 Township Marshall Primary Registration District No. 3038 Registered No. 73  
 City Marshall 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 30<sup>th</sup> 1931

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

17. I HEREBY CERTIFY, That I attended deceased from 13<sup>th</sup> April, 1931, to April 30, 1931, that I last saw her alive on April 30, 1931, and that death occurred, on the date stated above, at 3 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22-1883

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
93D Influenza  
11E

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
48 6 7

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work House wife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) myocarditis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) mo  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH Marshall, mo.

10. NAME OF FATHER Willis Lee

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

12. MAIDEN NAME OF MOTHER Sarah Hylte

(Signed) W. H. Madison, M. D.

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

, 19 (Address) Marshall mo.

14. INFORMANT Mamma Mc Kenney  
 (Address) \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview Cem DATE OF BURIAL May 3 1931

15. FILED 5-6 1931 Mrs. John H. McGuire  
 REGISTRAR

20. UNDERTAKER Ferguson weese ADDRESS Marshall

N. B.—every item of information should be carefully supplied. State amount of estate—burial. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MAY 27 1931



**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 Saline Registration District No. 796 File No. ....  
 Township ..... Primary Registration District No. 3038 Registered No. 73  
 City Marshall (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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
X 47 Y 6 X 8 X

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (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) .....

14. INFORMANT (Address) .....

15. FILED 5-6-31 Mrs. John H. McKnight REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 30 19 31

17. I HEREBY CERTIFY That I attended deceased from .....  
 ..... 19....., 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:

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 Exact statement of OCCUPATION is very important.  
 Information should be carefully supplied in plain terms, so that it may be properly classified.  
 CAUSE OF DEATH

**SUPPLEMENTARY**

5-16739