

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township..... Primary Registration District No. 1001
 City St. Joseph, (No. Missouri Methodist Hospital St. Ward)

File No. 27581
 Registered No. 889

2. FULL NAME Julia Elizabeth Montgomery

(a) Residence, No. 3328 Scott St. Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 17 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 7, 1929</u>		
7. AGE	YEARS	MONTHS
	<u>2</u>	<u>2</u>
		<u>17</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>child</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Saint Joseph, (STATE OR COUNTRY) Missouri

13. NAME John A. Montgomery

14. BIRTHPLACE (CITY OR TOWN) Milan, (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Jessie Mae Melvin

16. BIRTHPLACE (CITY OR TOWN) St. Joseph, (STATE OR COUNTRY) Missouri

17. INFORMANT John A. Montgomery (ADDRESS) 3328 Scott Street

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE AUG. 25, 1931

19. UNDERTAKER Heaton-Bigole-Bourman (ADDRESS) 319 S. 10th St. Forward Home

20. FILED 8-25-31 19 John R. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 24, 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 22 1931 to Aug 25 1931
 I last saw her alive on Aug 24 1931 Death is said to have occurred on the date stated above, at 3:15 p.m.
 The principal cause of death and related causes of importance were as follows:

Sub-pial hemorrhage over left frontal cerebral lobe
 Date of onset

Other contributory causes of importance:
Inevitable

Name of operation..... Date of.....
 What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify..... (Signed) J. M. Allaman, M. D.
 (Address) St. Joseph, Mo.

N.B.—Cause of death or in place of death should be stated. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH or in place of death. Exact statement of OCCUPATION is very important.

AUG 24 1931



1950-1951

1950-1951

**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 St. Joseph
Township St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No.
Registered No. 889
St. Ward)

2. FULL NAME

Julia Elizabeth Montgomery

(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

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)

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)

14.

INFORMANT (Address)

15.

FILED 10-3-31 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug 24 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.....)

THE CAUSE OF DEATH WAS AS FOLLOWS:

Subarachnoid hemorrhage
lower left frontal
central lobe
cause unknown

CONTRIBUTORY (SECONDARY)

Transition
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE.....

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

PARENTS

SUPPLEMENTARY

S-27581