

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

APR 29 1932

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

Do not use this space.

5861

1. PLACE OF DEATH *Clear* 769  
 County *Spokane* Registration District No. *769*  
 93 Township *Spokane* Primary Registration District No. *6015*  
 City (No. St. Ward)

2. FULL NAME *Karen Bruce*  
 (a) Residence, No. St. Ward.  
 (Usual place of abode)  
 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>J. B. Bruce</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Nov 25-1881</i>		
7. AGE <i>50</i> YEARS <i>2</i> MONTHS <i>70</i> DAYS	If LESS than 1 day, ..... hrs. or ..... min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housewife</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>235'</i>	
	10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Wheatland Mo 1</i>		
FATHER	13. NAME <i>DeBussan Shoemaker</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Iowa 2</i>	
MOTHER	15. MAIDEN NAME <i>Sarah Shepherd</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Iowa</i>	
17. INFORMANT <i>J. B. Bruce</i> (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Rosch Cemetery 2/28 122</i>		
19. UNDERTAKER <i>J. B. Woodruff</i> (ADDRESS)		
20. FILED <i>4 6</i> 1932 <i>J. P. Beene</i> <i>Registrar</i>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 20* 19*32*

22. I HEREBY CERTIFY, That I attended deceased from *10-14* 19*31* to *2-18* 19*32*  
 I last saw her alive on *2-14* 19*32* Death is said to have occurred on the date stated above, at *6154, m.*  
 The principal cause of death and related causes of importance were as follows:  
*Pyogenic Infection* Date of onset *10-5-31*  
*(around Great Trochanter (left hip) and Rim of Acetabulum)*  
*36*  
 Other contributory causes of importance:  
*Unknown*

Name of operation *none* Date of *X*

What test confirmed diagnosis? *clinical exp.* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? *No* Date of injury *X*, 19...  
 Where did injury occur? *none* (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *None*  
 Nature of injury *None*

24. Was disease or injury in any way related to occupation of deceased? *No*  
 If so, specify *No*

(Signed) *J. W. Richardson*, M. D.  
 (Address) *Tiffin Mo.*



**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. Clair Registration District No. 769  
Township Speedwell Primary Registration District No. 6015  
City (No. ....) St. .... Ward)

File No. ....  
Registered No. 6

**2. FULL NAME**

Karen Bruce  
(a) Residence, No. .... St. .... Ward.  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 25 1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>50</u>	<u>2</u>	<u>25</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) (STATE OR COUNTRY) Wheatland Pa

13. NAME Jafferson Shoemaker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Towanda Pa

15. MAIDEN NAME Sarah Sheppard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Towanda Pa

17. INFORMANT F. B. Bruce  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Rock Cem DATE 2/21 1932

19. UNDERTAKER F. B. Gendrich  
(ADDRESS)

20. FILED 5-16-1932 J. W. Dawson  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 20 1932

22. I HEREBY CERTIFY, That I attended deceased from 10-14-31 to 2-18-32

I last saw her alive on 2-14-32 Death is said to have occurred on the date stated above, at 6:15 a.m.

The principal cause of death and related causes of importance were as follows:

Septicemic infection  
abscess of great trochanter  
of acetabulum  
of hip  
and rim

Other contributory causes of importance: unknown

Name of operation no Date of .....  
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no Date of injury....., 19.....

Where did injury occur? none  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none

Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify no

(Signed) J. W. Richardson, M. D.  
(Address) Tiffin Mo

N. F. 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

1925-5