

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

Do not use this space.

8003

1. PLACE OF DEATH

County Franklin
Township
City Sullivan (No. _____)

Registration District No. 295
Primary Registration District No. 4129

File No. _____
Registered No. 18
St. _____ Ward _____

2. FULL NAME

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

Length of residence in city or town where death occurred 40 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 20, 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 05 2

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. 235

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Miller Co. (STATE OR COUNTRY) Missouri

13. NAME No Record

14. BIRTHPLACE (CITY OR TOWN) Shannon Co. (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Laura Reed

16. BIRTHPLACE (CITY OR TOWN) not known (STATE OR COUNTRY) _____

17. INFORMANT Chas West (ADDRESS) Sullivan, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buffalo Cem. DATE Mar. 24, 1932

19. UNDERTAKER J. J. Williams (ADDRESS) Sullivan, Mo.

20. FILED 3-23 1932 J. P. O'Quigan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 22, 1932

22. I HEREBY CERTIFY That I attended deceased from Feb 22, 1932 to March 22, 1932

I last saw her alive on _____, 19____ Death is said to have occurred on the date stated above, at 2:05 p.m.

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

Broncho Pneumonia

Date of onset

Other contributory causes of importance:

Chronic Dysentery

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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) Walter G. Mattox, M. D.
W. Sullivan Mo. (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.

APR 26 1932

