

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

Do not use this space.

8338

1. PLACE OF DEATH

County Jackson Registration District No. 1
Township 1st Primary Registration District No. 1
City Webb (No. 1st Hosp)

File No. 910
Registered No. 910
St. _____ Ward _____

2. FULL NAME

Margaret Francis Quinn

(a) Residence. No. Webb City Mo. 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 FE 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18 - 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
25 3 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 1

10. NAME OF FATHER Frank Perce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Webb 2

12. MAIDEN NAME OF MOTHER Rosie Gregg

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

14. INFORMANT Mrs Frank Perce

(Address) Webb City

15. FILED 3/4 1932 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 1932

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 19____, that I last saw _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ren. Pontonitis
140 140
129
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Septic abortion
cause unknown
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF (7)
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS autopsy
(Signed) Stanley S. Hall M. D.
3/4 1932 (Address) Webb City

*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 Webb City DATE OF BURIAL May 5, 32

20. UNDERTAKER Ross + Henderson ADDRESS 15th Jackson

30

11/15/1911

**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.....

Registration District No. 399

File No.....

Township.....

Primary Registration District No. 1802

Registered No. 910

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

2. FULL NAME

Marjorie Frances Quinn

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 4, 1932

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 18 1906

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 1 3 16

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

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

Name of operation..... Date of.....

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

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Nature of injury.....

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....

20. FILED 3/4 1932 M. M. Crowley Registrar

If so, specify (Signed)....., M. D. (Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-8338