

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

Do not use this space.

16817

1. PLACE OF DEATH

67 County Mississippi Registration District No. 566
 3 Township Charleston Primary Registration District No. 3030
 4 City Charleston (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 35

2. FULL NAME

Mary Jane Wainright
 (a) Residence. No. W. Commercial St., _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 2 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16, 1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
80 | 1 | 9

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

9. BIRTHPLACE (CITY OR TOWN) Shelbyville, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm. A. Turner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hickory 31
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Catherine Ann Settle

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

14. INFORMANT Mrs. A. L. Laska
 (Address) Charleston Mo.

15. FILED May 25th 1932 J. S. Vannon
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH 4:10 A.M.

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/25 1932

17. I HEREBY CERTIFY, That I attended deceased from 5/25, 1932, to 5/26, 1932 that I last saw h.E.R. alive on 5/25, 1932 and that death occurred, on the date stated above, at 4:10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
cerebral hemorrhage
 (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (1)
 IF NOT AT PLACE OF DEATH _____

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

WHAT TEST CONFIRMED DIAGNOSIS Clinical Symptom
 (Signed) E. Chas. Kalmus M. D.
 , 19 _____ (Address) Charleston Mo

*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 Monette, Mo. DATE OF BURIAL 5/26 1932

20. UNDERTAKER L. H. B. J. L. L. ADDRESS Charleston Mo.

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.

JUN 23 1932

