

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

Do not use this space.

2223

1. PLACE OF DEATH

County Linn
Township Clark
City Mason Mo (No. _____)

Registration District No. 972
Primary Registration District No. 3622

File No. _____
Registered No. 2
St. _____ Ward _____

2. FULL NAME

Mary Jane Colvard

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 8 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Linn Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Thomas Wilburn

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

12. MAIDEN NAME OF MOTHER Sarah Jane Wilburn

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

14. INFORMANT Henry Colvard
(Address) Mason Mo

15. FILED Feb. 1933 H. O. Shepherd
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1933

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1932, to Jan 31, 1933, that I last saw h. alive on Jan 31, 1933, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Interstitial Nephritis.
130
56 (duration) 1 yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physic Exam
(Signed) H. O. Shepherd, M. D.

Jan, 1933 (Address) Mason 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 _____ DATE OF BURIAL _____

Anderson Cemetery Feb 2 1933

20. UNDERTAKER _____ ADDRESS _____

Keuffner & Co Ind 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.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lincoln

Registration District No. 972

File No. 2

Township Moscow Mills

Primary Registration District No. 5652

Registered No. 2

City Moscow Mills No. _____ St. _____ Ward _____

2. FULL NAME

May Jane Clark

(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) m.

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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 1st
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) _____

FATHER
13. NAME _____

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

MOTHER
15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 - 1933

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

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

acute interstitial nephritis Date of onset _____

Other contributory causes of importance: 130

Bleumolism

Name of operation _____ Date of _____

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

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? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

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

5-2223