

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

Do not use this space.

13317

MAY 25 1934

1. PLACE OF DEATH

County Gasper Registration District No. 417
Township _____ Primary Registration District No. 3021
City Webb City (No. _____) St. _____ (Ward _____)

File No. _____
Registered No. 37

2. FULL NAME

America Nancy Streck
(a) Residence, No. 501 So. Roane 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) Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16, 1855
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 11 5

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. At Home
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) Greenfield Missouri

13. NAME James Allison
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Jane Allison
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT John Streck
(ADDRESS) Webb City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Carterville DATE Apr. 22, 1934

19. UNDERTAKER Steele Undertaking Co
(ADDRESS) Webb City, Mo.

20. FILED 4-23, 1934 J. D. Craig
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 21, 1934
22. I HEREBY CERTIFY, That I attended deceased from Dec 28, 19 to Apr 17, 1934
I last saw her alive on Feb 17, 1934. Death is said to have occurred on the date stated above, at 6 p. m.

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

Chronic Interstitial Nephritis

Other contributory causes of importance: _____

Name of operation _____ 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? _____ 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) R. M. Fortmont, M. D.
(Address) Webb City, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

