

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

Do not use this space.

**1. PLACE OF DEATH**

County HENRY  
Township  
City CLINTON (No. \_\_\_\_\_)

Registration District No. 347  
Primary Registration District No. 3018

File No. 16478  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 601 So Washington Ward \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 7 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 Married  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 25-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
90 8 22

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. \_\_\_\_\_

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warren Co Iowa

13. NAME Billie Call Cozier

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

15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT J A Trent  
(ADDRESS) Clinton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Cedarwood DATE 5-18 34

19. UNDERTAKER Fred Williams  
(ADDRESS) Clinton Mo

20. FILED 5-17 34 Dr J R Hampton  
Registrar.

**3 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-16-34

22. I HEREBY CERTIFY, That I attended deceased from April 15, 1934, to May 17, 1934.

I last saw him alive on May 16, 1934. Death is said

to have occurred on the date stated above, at 2:00 pm.

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

Fracture of skull by fall -  
Pneumonia -  
Broken hip on other side  
3 yrs ago  
Date of onset \_\_\_\_\_

Other contributory causes of importance:

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 \_\_\_\_\_

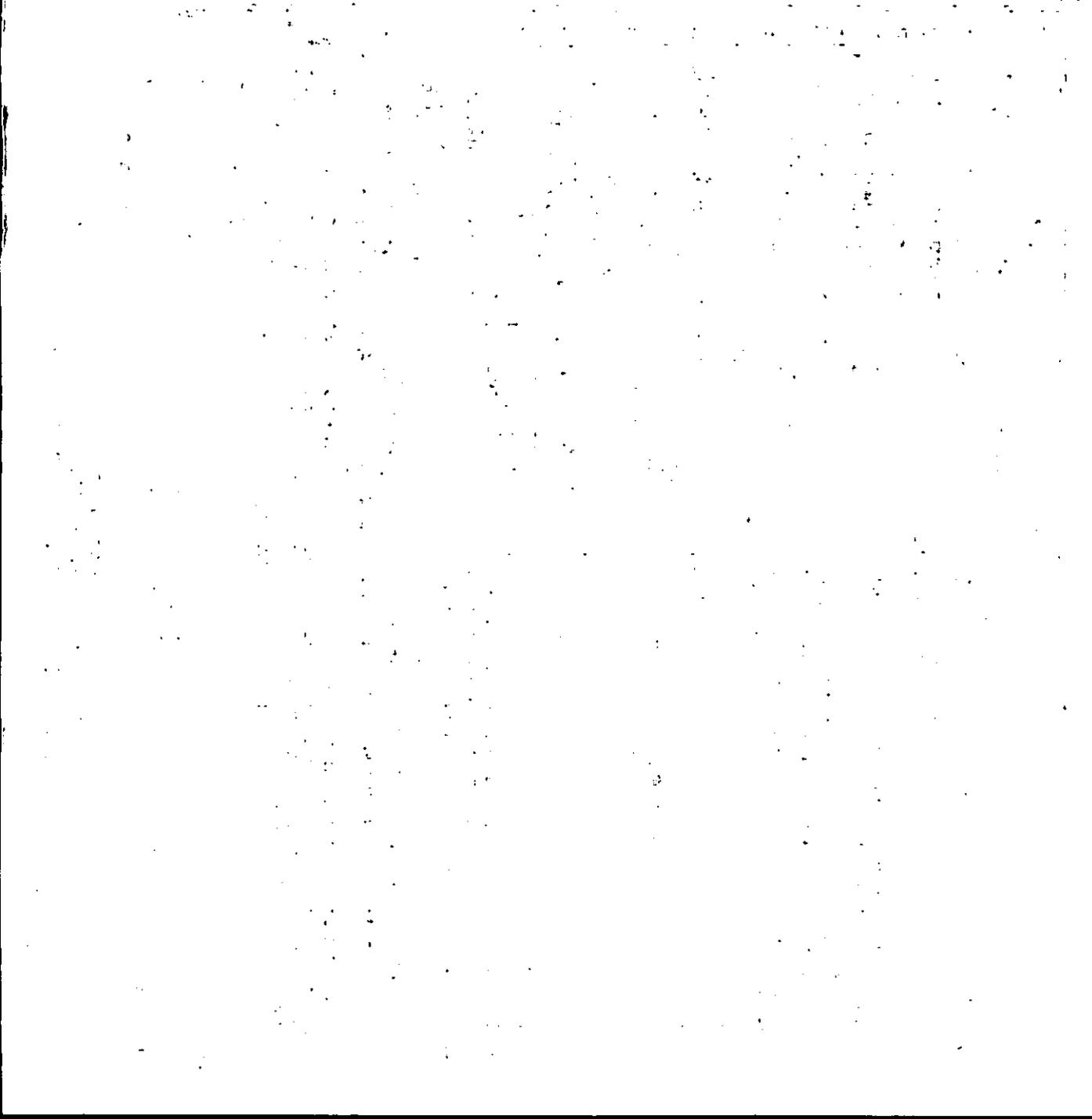
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

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

If so, specify \_\_\_\_\_

(Signed) Geo P. Hays D.O.  
(Address) Clinton Mo



#2 *Henry,*

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS *16478*

E. T. McLaughlin, M. D.,  
Special Agent,  
Jefferson City, Mo.

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mary E. Trent.

Who died at \_\_\_\_\_ on 5-16-1934

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex F. Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 80 Months 4 Days 22

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month April Year 1934

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: Fracture of neck of femur. Pressure Palsy. Pneumonia Hypostasis

Other contributory causes of importance Broken hip on other side 3 yrs ago

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? accident Date of injury May 14, 1934

Where did injury occur? at home. Fall from chair.  
Clinton, Mo. (Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall from chair

Nature of injury Broken hip

Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

Name of physician Geo. J. [unclear]

Address of physician Clinton, Mo.

Signature of Registrar \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 347

Very truly yours,

Primary Reg. Dist. No. 3018

*E. T. McLaughlin, M.D.*

Special Agent. *M.K.*

5-16478

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