

MAY 14 1936

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

Do not use this space.

14884

1. PLACE OF DEATH

 County Greene
 Township Murray
 City (No.)

 Registration District No. 323
 Primary Registration District No. 5448

 File No.
 Registered No.
 St. Ward

2. FULL NAME

Mary Ellen Mincks

(a) Residence, No. R.F.D. 1, Willard, Mo St. Ward.

(Usual place of abode)

 Length of residence in city or town where death occurred yrs. mos. ds. 3 28 How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 8, 1935
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 3 23

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

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) R.F.D. 2, Willard Mo

 MOTHER 13. NAME Garley E. Mincks

 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rogersville, Mo

 15. MAIDEN NAME S. Marie Appleby

 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sitka, Kansas.

 17. INFORMANT Mrs Ross Appleby,
 (ADDRESS) R.F.D. 2, Willard, Mo

 18. BURIAL, CREMATION OR REMOVAL PLACE Rose Hill DATE Apr. 7, 1936

 19. UNDERTAKER (ADDRESS) Greenwade, Willard, Mo

 20. FILED Apr. 7, 1936 Mrs. R. Hughes
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 6, 193622. I HEREBY CERTIFY, That I attended deceased from 3-28 1936 to 4-6 1936I last saw her alive on 4-6 1936 Death is saidto have occurred on the date stated above, at 4 P. m.

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

Capillary BronchitisDate of onset 3/28/36

Other contributory causes of importance

Name of operation None Date of ✓What test confirmed diagnosis? Usual Was there an autopsy? No23. 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)

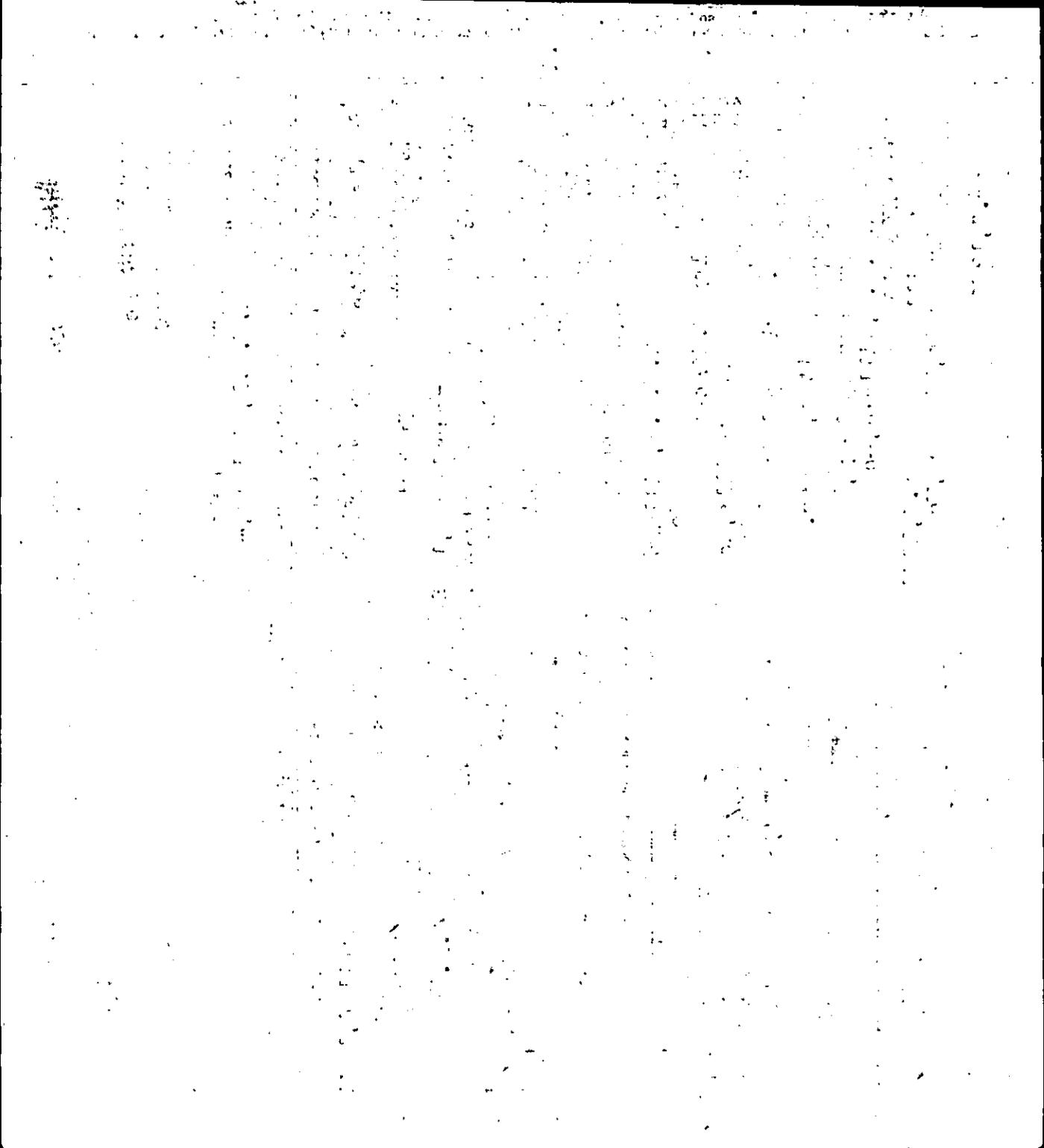
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓Nature of injury ✓24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Bob Hinkle, M. D.(Address) Brisbane 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.



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

Do not use this space.

1. PLACE OF DEATH

County Green

Registration District No. 323

Township Murray

Primary Registration District No. 3448

City (No. _____)

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

F

W

Inf.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 6 1936

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw him _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, specify in min.

3

23

Capillary Bronchitis
Acute (Primary)

Date of onset

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

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

13. NAME

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

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 July 16 1936 Mrs. Ralph Hughes
Registrar.

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) B. J. Wandle, M. D.

(Address) Bols Blue mo

SUPPLEMENT

1038

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10841-5-14889