

APR 17 1939

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

9774
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township 1st Primary Registration District No. 1002
(c) City Brooklyn (d) Street No. 17 E. Gen Hosp Registered No. 1380
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Nollie Fenton
(a) Residence, No. 3017 Brooklyn St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, give county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lloyd Fenton
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 28-1900
7. AGE YEARS 38 MONTHS 11 DAYS ✓ If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as 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) MO
13. NAME John Harper
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
15. MAIDEN NAME Mollie Smith
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
17. INFORMANT (ADDRESS) Recd. Clerk R. C. Gen Hosp
18. BIRTH, DEATH, OR REMOVAL PLACE DATE Family MO 3-31-39
19. FUNERAL DIRECTOR (NAME AND ADDRESS) John B. Campbell 536 Campbell
20. FILED March 1, 1939 W. A. Grove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30-39, 19
22. I HEREBY CERTIFY, That I attended deceased from 3-6-39, 19, to 3-30-39, 19.
I last saw W alive on 3-30-39, 19. Death is said to have occurred on the date stated above, at 4:30 a.m.
The principal cause of death and related causes of importance were as follows:
varicella abscesses
chronic salpingitis
(etiology unknown)
Other contributory causes of importance: 137B
Name of operation One sacculus - oophorectomy Date of 3-25-39
What test confirmed diagnosis? Was there an autopsy? MO
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) P. J. De Maria M. D.
R. C. Gen Hosp
W. A. Grove

WRITE PLAINLY WITH LEADING 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.

FORM 1 X14028

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.