

FILED JUN 10 1941

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

Do not use this space.

19689  
17392

1. PLACE OF DEATH

County Hallaway

Registration District No. 102

Township Trayvoss

Primary Registration District No. 4062

City Trayvoss (No. 10)

File No. \_\_\_\_\_

Registered No. 38

2. FULL NAME Irene Edgetta Balbreath

(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 Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 29 1941

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

22. I HEREBY CERTIFY that I attended deceased from May 19 1941 to May 29 1941

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 19 1941

I last saw her alive on May 28 1941 at 10:30 p.m. Death is said to have occurred on the date stated above, at 10:30 p.m.

7. AGE YEARS 0 MONTHS 0 DAYS 10 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

Malnutrition

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 \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Trayvoss, Hallaway Co, Mo

13. NAME Robt Eubank

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

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

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

15. MAIDEN NAME Louise Balbreath

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Trayvoss, Hallaway Co, Mo

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

17. INFORMANT (ADDRESS) Adeline Balbreath Trayvoss, Mo

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Glendale Hill DATE May 30 1941

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

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no If so, specify \_\_\_\_\_

20. FILED May 30 1941 G.B. Nichols Registrar.

(Signed) G.B. Nichols M. D. (Address) Trayvoss, 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.

158

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19689

Registration District No. 102

Primary Registration District No. 4062

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Calloway  
(b) City or town Marion  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Calloway  
(c) City or town Marion  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Irene Euzella Gallbreath

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race Black

6. (a) Single, widowed, married, divorced Int

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

10

hr. min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_

(Date received local registrar)

(b) \_\_\_\_\_

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Malnutrition  
Premature and not  
properly developed  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B.B. Nichols (M. D. or other) \_\_\_\_\_  
Address Calloway MO Date signed 7-17-41

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

19689