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

Do not use this space.

17615-B

File No. 17615-B
Registered No. 56

1. PLACE OF DEATH
County Clay
Registration District No. 201
Township
Primary Registration District No. 3012
City Liberty (No. .... St., ... Ward)

2. FULL NAME Jane Ewing

(a) Residence. No. .... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 6" 1836

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
93			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER James Boggus
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Sarah Brawley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ky

14. INFORMANT Chas Thompson
(Address) Liberty Mo.

15. FILED 8/10/29 19.. Wm H Goodson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1929

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 29, 1929 that I last saw her alive on May 29, 1929, and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis
(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) General Artero Sclerosis
(duration) 10 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? .... DATE OF ....
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Burton Maltby, M. D
May 30, 1929 (Address) Liberty Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Fairview
DATE OF BURIAL: May 31 1929

20. UNDERTAKER: N. W. Rice
ADDRESS: Liberty Mo

1929
98
2
2
CAUSE

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH
County Clay — Registration District No. 201 — File No.
Township Liberty — Primary Registration District No. 3012 — Registered No. 56
City Liberty (No. ________ St. ________ Ward)

2. FULL NAME Jane Ewing

(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

3. SEX F
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 6 - 1836

7. AGE — YEARS 92 — MONTHS 6 — DAYS 23 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 9/12/29 Wm H Goodson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1929

17. I HEREBY CERTIFY, That I attended deceased from ________, 19__, to ________, 19__, that I last saw h___ alive on ________, 19__, and that death occurred, on the date stated above, at ________ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis from Cerebral Haemorrhage
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (SECONDARY) General Arteriosclerosis
(duration) ___ yrs. ___ mos. ___ ds.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ________ DATE OF ________
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ________, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

N. B.—[illegible] 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.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE [illegible]

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