

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

Do not use this space.

29985

1. PLACE OF DEATH

County Barry Registration District No. 29
 Township Flat Creek Primary Registration District No. 4021
 City Cassville (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 64
 St. _____ Ward _____

2. FULL NAME

Mary Jane Chappell
 (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 Female 4. COLOR OR RACE wh 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) Jan 11, 1880
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 8 18
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Illinois
 10. NAME OF FATHER Hamilton Adams
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT Jess Chappell (Address) Cassville Mo
 15. FILED Nov. 19 29 Mrs H.R. Williams REGISTRAR Dpt.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1929
 17. I HEREBY CERTIFY, That I attended deceased from Sept 22nd 1929 to Sept 29th 1929 that I last saw her alive on Sept 29th 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexia
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) probably Age (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS None
 (Signed) D. G. Mitchell, M. D.
 _____, 19 _____ (Address) Cassville 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 Harner DATE OF BURIAL 10/1/29
 20. UNDERTAKER Home Funeral ADDRESS Sequoy Cassville

WRITE PLAINLY, WITH UNFADING 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.

REPRODUCED FROM THE MISSOURI STATE BOARD OF HEALTH

