

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

Do not use this space.

MAY 14 1936

13646-1

1. PLACE OF DEATH

County Montana
Township Sum
City (No. _____) _____

Registration District No. 574
Primary Registration District No. 5772a

File No. 1935
Registered No. 40
Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-20-35

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

22. I HEREBY CERTIFY, That I attended deceased from 4-13-35 to 4-29-35

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 4-1856

I last saw her alive on 4-19-35 1935 Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS 78 MONTHS 6 DAYS 16 If LESS than 1 day, _____ hrs. or _____ min.

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

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

Acute Gastroenteritis Date of onset 4/15/35

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, months, and days) spent in this occupation _____

Other contributory causes of importance: Ch. Valvular Disease of Heart

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

13. NAME William Wagoner

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

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Wm H. Hays (ADDRESS) Sum, Montana

18. BURIAL, CREMATION OR REMOVAL PLACE Sum, Montana DATE 4-22-35

19. UNDERTAKER Sum, Montana (ADDRESS) _____

20. FILED 4/22/35 Ellis Drake 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) A. L. Meredith, M. D.

(Address) Frank Stone, 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.

