

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

Do not use this space.

2579

1. PLACE OF DEATH
 County Ray Registration District No. 744
 Township Richmond Primary Registration District No. 3035
 City Richmond (No.) St. Ward (....)

2. FULL NAME Harriet J. Cato
 (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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James J. Cato
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 28, 1856
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
74 8 7
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) Richmond; (STATE OR COUNTRY) Mo
 PARENTS
 10. NAME OF FATHER Wm Cross
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Leraba Ware
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo (STATE OR COUNTRY)
 14. INFORMANT Mrs John Taylor (Address) Richmond Mo
 15. FILED 1-8-1931 B. E. Day REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931
 17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930 to 1, 3, 1931 that I last saw her alive on 1, 3, 1931, and that death occurred, on the date stated above, at 11 a m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Intestine
4 1/2 (duration) 2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? 0 DATE OF
 WAS THERE AN AUTOPSY? 0
 WHAT TEST CONFIRMED DIAGNOSIS? Chemical
 (Signed) E. M. Young M. D. (Address) Richmond
 *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 Yerborne DATE OF BURIAL 1-8-1931
 20. UNDERTAKER Jno W. Gipschill ADDRESS Yerborne

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.

JAN 27 1931

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

ALL INFORMATION CALLED FOR MUST BE SUPPLIED IN THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Ray
Towship Richmond
City Richmond (No.) St. Ward)

Registration District No. 744
Primary Registration District No. 3033

File No.
Registered No. 2

2. FULL NAME

Harriet J. Cato

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

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

7. AGE YEARS MONTHS DAYS 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)

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 1-8-31 E. E. Gay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1931

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that (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:

Capsular pneumonia & infestation (diarrhoeal)

18. WHERE WAS DISEASE CONTRACTED (duration) mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? (duration) yrs. mos. ds.

DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY? DATE OF

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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

4/24/31

RP

S-2519