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

3105

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.

1. PLACE OF DEATH
County Ray Registration District No. 740 File No.
Township Crooked River Primary Registration District No. 5973 Registered No. 74
City (No. St. Ward)

2. FULL NAME Belle Mitchel

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-24-1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	11	

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) House Keeper
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ray Co Mo

PARENTS

10. NAME OF FATHER John H. Rader
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Rockingham Co Va
12. MAIDEN NAME OF MOTHER Rhoda Jane Stratton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ray Co Mo

14. INFORMANT Charles Rader
(Address) Hardin Mo

15. FILED Jan 18 1929 Jno W. Knipschild REGISTRAR

V MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 5, 1929
that I last saw h.er alive on Jan 4, 1929, and that death occurred, on the date stated above, at 10 30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis.
(duration) 18 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Myocarditis
(duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Carl H Reed, M. D
, 19 (Address) Hardin.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Hickory Grove Cem	Jan 5 - 1929
20. UNDERTAKER	ADDRESS
Jno W. Knipschild	Hardin Mo.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. .....Ward)

2. FULL NAME .....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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:

.....

.....

.....

.....(duration).....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?..... 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. (See reverse side for additional space.)

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

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD