

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

Do not use this space.

4625

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. _____

Township Springfield

Primary Registration District No. 2001

Registered No. _____

(No. _____)

843 7 Grant St. _____ Ward _____

2. FULL NAME

Blanche C McKenna

(a) Residence, No. 843 7 Grant St., _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 25 - 1878

7. AGE YEARS 55 MONTHS 6 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

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

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) spent in this occupation _____

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

13. NAME George Skull

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE St Marys DATE 2-3 1934

19. UNDERTAKER (ADDRESS) H. B. Jemmon

20. FILED 3-2-34 Springfield Mo.

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 28 1934

22. I HEREBY CERTIFY, That I attended deceased from Max 1932 to 2/28 1934
 I last saw her alive on 2/28 1934 Death is said to have occurred on the date stated above, at 7:58 m.
 The principal cause of death and related causes of importance were as follows:

Diabetes Mellit. + s/
Apoplexy, Hemiplegia
Fractured femur
 Date of onset Jul 33
2/21/34

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

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? No
 If so, specify _____
 (Signed) H. B. Jemmon M. D.
 (Address) Springfield, 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.

7. Ave. Set -
See next slide
(Corner of Room)

#2

Greene

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS 4625

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

5-1

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Blanche C. McKeena

Who died at _____ on Feb - 28 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex F. Color or race W ~~Single, married, widowed or divorced:~~ _____

Date of birth _____ Age: Years 55 - Months 6 Days 3

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Diabetes Mellitus

Other contributory causes of importance apoplexy & Lemplogia, fracture of jaw

Name of operation _____ Date of Apr 10 1934

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? accident 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 Fallen in home

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar John W. [unclear] Date filed 9/27/33

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. dist. No. 318

Primary Reg. Dist. No. 2001

E. T. McGaugh, M. D.
Special Agent.

S-4655

1934

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1934