

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

Do not use this space.

OCT 24 1927

26397

1. PLACE OF DEATH

County Andrew Registration District No. 26
Township Salt Spring Primary Registration District No. 3002
City Mexico Andrew's Hospital St. Mo Ward

File No.
Registered No. 121 St. Ward

2. FULL NAME Jessie B. Bunker

(a) Residence Calark Mo 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.

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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-9-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 59

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Samuel M. Robertson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tex
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Marquet A. Austin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT A. J. Bunker
(Address) Calark Mo

15. Sept 3rd 1927 Ira S. Milligan
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-3-1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1927, to left, 1927 that I last saw her alive on Sept 3rd, 1927, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer 46E
for some time
fat of yellow reddish
color of blood
(duration) yrs. mos. ds. 13

CONTRIBUTORY (SECONDARY) 4410
(duration) yrs. mos. ds.

18. WHERE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) Paul E. Col, M. D.

, 19 Mo (Address) Mexico 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 Calark Mo Cem DATE OF BURIAL 9-4-1927

20. UNDERTAKER HA Buecht & Son ADDRESS Mexico 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County DeKalb Registration District No. 26 File No. _____
 Township Salisbury Primary Registration District No. 3002 Registered No. 121
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Jennie Burkey
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1
57 is all the information I can get.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work I wrote to A.J. Burkey asking for further information but have received no answer yet. (duration) _____ yrs. _____ mos. _____ da.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ CONTRIBUTORY (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Yes

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 A.J. Burkey (Address) blank No.

15. Sept 3rd 1927 Ira S. Mulligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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 _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 FULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-265-97

