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

Do not use this space.

206

1. PLACE OF DEATH
County: Boone — Registration District No. 13 — File No. 16
Township: Columbia — Primary Registration District No. 3006 — Registered No.
City: Columbia (No. ..., ... St., ... Ward)

2. FULL NAME: Margaret P. Bruce
(a) Residence. No. 127 Sexton Road St., ... Ward. (If nonresident give city or town and State)
(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

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: John T. Bruce

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 2 1847

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
81	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ~~Farmer~~ / Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (CITY OR TOWN): Moniteau Co
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: E. H. Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): N. Carolina
12. MAIDEN NAME OF MOTHER: Jane Vivion
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: W. C. Wisser
(Address)

15. FILED 1/11, 1929 Beatrice Gribb, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 10 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to Jan 9, 1929, that I last saw her alive on Jan 9, 1929, and that death occurred, on the date stated above, at 8:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia 107A
Primary
(duration) ... yrs. — mos. ... ds.

CONTRIBUTORY (SECONDARY): Senility
(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? Physical Exam
(Signed) E. D. Bartlett, M.D.
1/10, 1929 (Address) Columbia 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	DATE OF BURIAL
Mt Zion - Moniteau Co	Jan 12th 1929

20. UNDERTAKER	ADDRESS
W. C. Wisser	Columbia

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.

10
3
8
235
1
2
1

Baskett

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH
County *Boone* Registration District No. *73* File No. *16*
Township Primary Registration District No. *3006* Registered No.
City *Columbia* (No. St. Ward)

2. FULL NAME *Margaret P. Bruce*
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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

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

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 *3-18*, 19*29* *Beatrice Grubbs* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 18* 19*29*

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:
Pneumonia
Broncho
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

1000

SUPPLEMENTARY

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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