

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

Do not use this space.

1. PLACE OF DEATH

County Madison @
Township Mana Matte Me
City Thos of Mabry (No. _____)

Registration District No. 538
Primary Registration District No. 6230

File No. 21133
Registered No. 46
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. _____ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch 4 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 3 2

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

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) Mo

13. NAME Joshua Mabry

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont, Knopf

15. MAIDEN NAME Dont Thow

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

17. INFORMANT Hy Mabry
(ADDRESS) Bourne Iron Co

18. BURIAL, CREMATION, OR REMOVAL PLACE Bourne Iron Co DATE _____ 19

19. UNDERTAKER Calwell Bros
(ADDRESS) Flat Bourne Mo

20. FILED June 5 1934 B. C. Slaughter
Registrar.

By A. A. Schwaner

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 5 1934

22. I HEREBY CERTIFY, That I attended deceased from June 5 1934 to June 5 1934. I last saw him alive on June 5 1934. Death is said to have occurred on the date stated above, at 745.

The principal cause of death and related causes of importance were as follows:

Nephritis Interstitial Date of onset 24 15
Valvular Heart lesion

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? autopsy as 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.

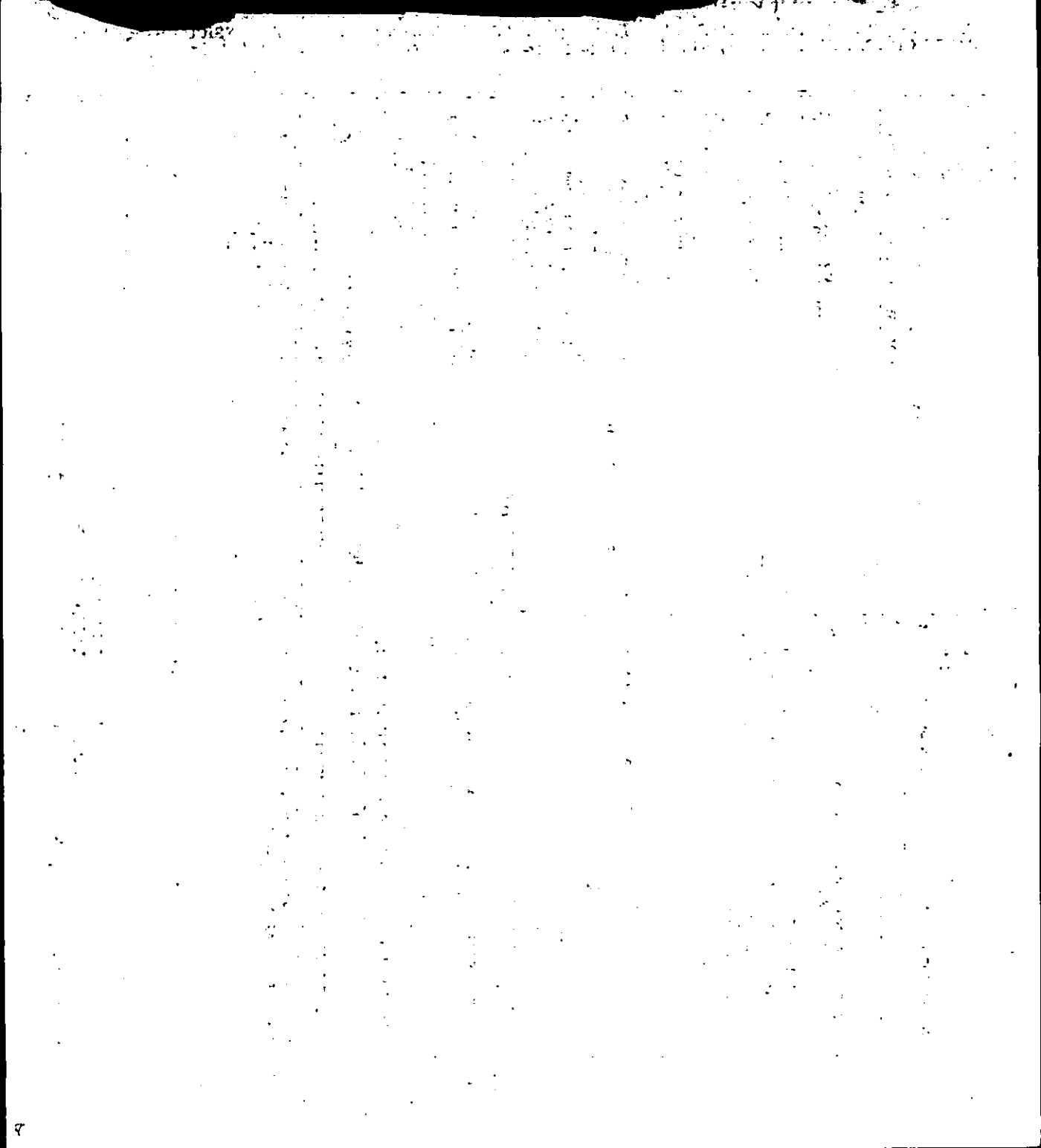
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) M. Mabry M. D.
(Address) Bourne Iron Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 13 1934

WHITE PLAIN



Madison

WASHINGTON

46

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: *Thos W Mabery*
Who died at _____ on *June 5-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

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

Sex *m* Color or race *w* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *83* Months *3* Days *2*

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 *13* Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Interst nephritis Chronic*

Other contributory causes of importance *Valvular heart lesion*

Name of operation _____ Date of _____

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? _____ 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 _____

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

If so, specify _____

Name of physician _____

Address of physician *B. C. S. Laughlin*

Signature of Registrar *Ray C. D. Schuman*

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,
E. T. McLaughlin M.D.

Reg. Dist. No. 538

Primary Reg. Dist. No. *6230*

Special Agent. *gc*

WITH ONSAIDING INK--THIS IS A PERMANENT RECORD

5-21133

(2)