

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

Do not use this space.

20996

1. PLACE OF DEATH

County..... *Cole*
 Township.....
 City..... *Jefferson* (No.....)

Registration District No..... *213-*
 Primary Registration District No..... *3014-*

File No.....
 Registered No..... *177-*
 St..... Ward)

2. FULL NAME

(a) Residence. No..... St..... Ward.....

(Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* | 4. COLOR OR RACE *white* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec-17-1926*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
 ——— 6 20

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) *Jefferson City Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Wesley Willis*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Miller Co Mo*

12. MAIDEN NAME OF MOTHER *Callie M Lough*

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

14. INFORMANT (Address) *Wesley Willis Jefferson City Mo*

15. FILED *7/18/27* *P. V. Bedford* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 7* 19*27*

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 17*, 19*26*, to *July 7*, 19*27*. that I last saw her..... alive on *July 7*, 19*27*, and that death occurred, on the date stated above, at..... *5:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute summer complaint

CONTRIBUTORY (SECONDARY) *none* (duration)..... yrs..... mos..... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS..... *clinical*
 (Signed)..... *W. A. Clark*, M. D.

*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 *Chamoin Mo* DATE OF BURIAL *7/8* 19*27*

20. UNDERTAKER *Wymore Gordon J.C.M.W.* 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.

RECORDING INFORMATION IS A PERMANENT RECORD

AUG 16 1927

