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

Do not use this space.

30894

1. PLACE OF DEATH
County: Livingston
Township:
City: Chillicothe (No. ..... St. ..... Ward)

Registration District No. 508
Primary Registration District No. 3026

File No.
Registered No. 108

2. FULL NAME Mrs Maria E. Spaulding
(a) Residence. No. 109 E Herriman St., 3 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 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: Livingston H. Spaulding

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 3 - 1837

7. AGE: Years 69 | Months 10 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(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): New London Iowa

PARENTS
10. NAME OF FATHER: R. C. Spaulding
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): New York N. York
12. MAIDEN NAME OF MOTHER: Ann M. E. Power
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Lyndon Vermont

14. INFORMANT: F. H. Spaulding
(Address): Chillicothe Mo

15. FILED 10-27 1927 Reuben Barnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 24 1927

17. I HEREBY CERTIFY, That I attended deceased from May 4 1927 to Oct 24 1927 that I last saw him alive on Oct 24 1927, and that death occurred, on the date stated above, at 5-30 P m m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
1829
102 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): High Blood Pressure (duration) 2 yrs. mos.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr Orsa Hyde D.C., M. D.
10-27 1927 (Address) Chillicothe

*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: Edgewood Cemetery — DATE OF BURIAL: 10-27 1927

20. UNDERTAKER: F. B. Norman — ADDRESS: Chillicothe Mo

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.