

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

Do not use this space.

34528

1. PLACE OF DEATH

County St. Louis Registration District No. 784
Township St. Ferdinand Primary Registration District No. 6030
City Kentock, Mo (No. 220) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Hattie Wright Fairwell

(a) Residence. No. 2, Kentock 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Cal 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 20 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
45 5 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) White Station
(STATE OR COUNTRY) Tex.

10. NAME OF FATHER Harold Wright

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

12. MAIDEN NAME OF MOTHER Agnes Wright

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

14. INFORMANT Chas Fairwell
(Address) South Kentock

15. FILED 11-3, 1927 O. V. Schuck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-1 1927

17. I HEREBY CERTIFY That I attended deceased from 11-1 1927, to 11-1 1927, that I last saw h. e. alive on 11-1 1927, and that death occurred, on the date stated above, at 11-1 11:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stroke (Cerebral Hemorrhage)

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) 9 hrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH? _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) Ray Johnson M.D.
11-3, 1927 (Address) Ferguson 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 Memphis Tenn DATE OF BURIAL 11-4-1927

20. UNDERTAKER Peoples and Co ADDRESS Franklin

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.

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RECORD

