

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

Do not use this space.

37531

1. PLACE OF DEATH

County Madison
Township St. Michael
City St. Michael (No. 3723)

Registration District No. 538
Primary Registration District No. 3029

File No. _____
Registered No. _____
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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 1955

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 | 5 | 13 | _____

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Indio, Calif.
(STATE OR COUNTRY)

10. NAME OF FATHER Fisher

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

12. MAIDEN NAME OF MOTHER Doutson

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

14. INFORMANT J. M. Craig
(Address) Indio, Calif.

15. FILE NO. 31 1927 REGISTRAR C. Walters

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 31 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 1927 to _____, 1927 that I last saw him alive on Dec 19 1927 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

renal arterio-sclerotic disease
92A (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) 90A (duration) _____ yrs. _____ mos. _____ da.

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) W. M. Daulton M. D.
, 19 _____ (Address) Indio, Calif.

*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 _____

20. UNDERTAKER Methodist Lu ADDRESS Indio 1928
E. J. Webb Indio, Calif.

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.

