

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.

MAR 21 1928 *Blunmady*

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

Do not use this space.

5913

1. PLACE OF DEATH

County *Pelliss*  
Township *Bowling Green*  
City *Idalia* (No. ....)

Registration District No. *1670*  
Primary Registration District No. *5893*

File No. *73*  
Registered No. *3*  
St. .... Ward)

2. FULL NAME

*Columnia C Hendon*

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* 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 *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *widow of I B Hendon*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 8 - 1846*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*83* | *1* | *13*

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) *Retired*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Madison Co Virginia*  
(STATE OR COUNTRY)

10. NAME OF FATHER *J. M. Yowell*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Shelby Virginia*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Abmna Yowell*

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

14. INFORMANT *Miss W. M. C. Connick*  
(Address) *Idalia Mo*

15. FILED *2/28 1928* *Flossie Ferguson*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2 X 21 19 28*

17. I HEREBY CERTIFY That I attended deceased from *Feb 20 1928* to *Feb 21 1928* that I last saw *her* alive on *Feb 21 1928*, and that death occurred, on the date stated above, at *12:20 a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral thrombolyse*

*80 yrs at attack & general*  
(duration) yrs. .... mos. .... da.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF .....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *J. Blunmady*, M. D.  
(Address) *316 S Ohio Idalia 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 *Mt Hope Cooper Co* DATE OF BURIAL *2/23 1928*

20. UNDERTAKER *McLaughlin Bros* ADDRESS *Idalia*

