AUG 28 1920

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

Do not use this space.

1. PLACE OF DEATH

County: Ray — Registration District No.: 743 — File No.: 24826

Township: Fishing River — Primary Registration District No.: ~~59772~~ 6237 — Registered No.: 34

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME John L. Hanway

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

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 20 1866.

7. AGE: Years 61 — Months 9 — Days 5 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(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): Ohio

PARENTS

10. NAME OF FATHER: Frank Hanway
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Rebecca White.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

14. INFORMANT: C. J. Heath
(Address): Excelsior Springs Mo.

15. FILED July 28 1928 H. L. E. Ellison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 25 1928

17. I HEREBY CERTIFY, That I attended deceased from 1925, 19....., to July 25th, 1928 that I last saw him alive on July 25th 1928, 19....., and that death occurred, on the date stated above, at 4.30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82 A 74 A
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY): previous attacks over several years (duration) ..... yrs. ..... mos. ..... ds.

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? none

(Signed) [signature], M. D
, 19 (Address) 329 E. Broadway Excelsior Springs 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: Monti Vesta Colo — DATE OF BURIAL: Dont Know

20. UNDERTAKER: Herbert Hope — ADDRESS: Ex Springs

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.