

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

Do not use this space.

28385

1. PLACE OF DEATH

County Mississippi Registration District No. 566 File No. _____
 Township Waverly Primary Registration District No. 5762 Registered No. 83
 City Charleston (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. RFD # 3 St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Odine Layton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
75 | 5 | 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Pape, Thiardeau (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Willeys

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) RFD # 3 - Charleston Mo.

15. File No. Aug 26th 1929 Registrar F S Vermin

MEDICAL CERTIFICATE OF DEATH

5:20 A.M.

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 25 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1929 to Aug 25 1929 that I last saw h. alive on Aug 25 1929, and that death occurred, on the date stated above, at 5:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
 (duration) ____ yrs. ____ mos. ____ da.

CONTRIBUTORY (SECONDARY) arterio-sclerosis
 (duration) 45 yrs. ____ mos. ____ da.

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 clinical symptoms
 (Signed) R. M. Champion, M.D.
 , 19 (Address) Charleston 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 Calvary Cemetery DATE OF BURIAL 8-26 1929

20. UNDERTAKER Lair and Co. Inc. ADDRESS Charleston

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