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

Do not use this space.

30236

1. PLACE OF DEATH
County Caloway
Township
City Fulton (No. ..... St. ..... Ward)

Registration District No. 104
Primary Registration District No. 3008

File No.
Registered No. 206

2. FULL NAME Addie Cason

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

Length of residence in city or town where death occurred yrs. 4 mos. 21 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 N. A. Cason

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

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	7	10	

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) Ky
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Harrison Dejarnette
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Polly Swinford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Hospital records
(Address)

15. ~~Oct 1 29~~ R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1929

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to Sept 29, 1929, that I last saw her alive on Sept 29, 1929, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
99
16W
Probably (duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
Senility (duration) yrs. mos. ds.

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) D. C. Adams, M. D.
, 19 (Address) Fulton 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: Montgomery City Cemetery
DATE OF BURIAL: Oct 2 1929

20. UNDERTAKER: C. W. Hopkins
ADDRESS: Montgomery City

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.

14
22 1929
3
7
235
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Callaway Registration District No.: 104 File No.:
Township: Primary Registration District No.: 3008 Registered No.: 206
City: Fulton (No. , St. Ward)

2. FULL NAME: Addie Cason

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-19-1846

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
83	7	10	

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Oct 31, 1929 R. N. Crewe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

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) , M. D.
, 19 (Address)

*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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-30236