SEP 25 1929

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

Do not use this space.

31222

1. PLACE OF DEATH

County: Lafayette — Registration District No.: 460 — File No.:

Township: — Primary Registration District No.: H 274 — Registered No.: 66

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

2. FULL NAME Myrtle ~~[illegible]~~ Dyer Curtis

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

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: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1888

7. AGE: 41 — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Higginsville, Mo.

PARENTS

10. NAME OF FATHER: Nick Dyer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Fannie Perry
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: Fannie Perry
(Address): Higginsville, Mo.

15. FILED 9-5, 1929 — Bessie P. Porter, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 4, 1929, that I last saw her alive on Sept 4, 1929, and that death occurred, on the date stated above, at 6 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis pulmonary
134
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 31
(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? Physical Signs
(Signed) W. P. Koppenhink, M.D.
Sept 4, 1929 (Address) Higginsville 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: Colored Brand — DATE OF BURIAL: 1929

20. UNDERTAKER: Colored Brand — ADDRESS: Higginsville Mo

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.