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

Do not use this space.

36624

1. PLACE OF DEATH
County Cheriton
Township Bee Branch
City ..... (No. ..... St. ..... Ward)

Registration District No. 175
Primary Registration District No. 5246

File No. 8
Registered No. 8

2. FULL NAME Bettie Lou Fann (Farr)

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2-1928

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
0	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None Baby
(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) Cheriton Co Mo

PARENTS
10. NAME OF FATHER Charley Monroe Fann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cheriton Co Mo
12. MAIDEN NAME OF MOTHER Della Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cheriton Co Mo

14. INFORMANT Henry Fann
(Address) New Cambria Mo

15. FILED 11/27 1929 W. J. Billeter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 16, 1929 that I last saw her alive on Nov 15, 1929, and that death occurred, on the date stated above, at 7 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Osteomyelitis of the Left Arm

154 (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) 155a (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? —
(Signed) Co West, M. D
Nov 16 1929 (Address) New Cambria 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: Johnson Cemetery
DATE OF BURIAL: Nov 17 1929

20. UNDERTAKER: J. E. Gillelund
ADDRESS: New Cambria 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.

DEC 19 1929