

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

Do not use this space.

37888

1. PLACE OF DEATH

County New Madrid Registration District No. 604
 Township Spain Primary Registration District No. 5798
 City Port Republic (No.) St. Ward)

File No. 8
 Registered No.

2. FULL NAME

Minnie Husley
 (a) Residence No. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. 10 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-28-1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, specify hrs. or min.
60 2 1

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

10. NAME OF FATHER Wm Houston

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT (Address) John Atberry
Crossan

15. FILED 11-20-30 W. B. Anthony REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-28-1929

17. I HEREBY CERTIFY, That I attended deceased from 11-28-1929, to 11-28-1929, 1929 that I last saw him alive on 11-27-1929, 1929, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 7/401
 (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) H. J. Kelly, M. D.
 , 19 1929 (Address) Port Republic MO

*State the DISEASE CAUSING DEATH, or if 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 New Hope DATE OF BURIAL 11/29/29

20. UNDERTAKER A. M. Payne ADDRESS Port Republic

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.

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