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

Do not use this space.

672

File No. .....
Registered No. 1

1. PLACE OF DEATH
County: Franklin — Registration District No. 282
Township: ..... — Primary Registration District No. 4166
City: Campbell (No. ..... St. ..... Ward)

2. FULL NAME Minerva Jane White

(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)
Fem.	White	—

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7 - 1835

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	94	7	7	

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

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

14. INFORMANT J. F. White
(Address) Campbell

15. FILED 1/15, 1930 E. W. Sanders REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1930 to Jan. 13, 1930 that I last saw h. alive on Jan. 13, 1930, and that death occurred, on the date stated above, at 6 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
82 A
99 (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (SECONDARY) Senile
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) M. L. Cone, M. D.
, 19 (Address) Campbell, 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	DATE OF BURIAL
Bethany Cem.	1/15 1930
20. UNDERTAKER E. W. Sanders	**ADDRESS** Campbell

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.