APR 28 1930

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

Do not use this space. 744-2

1. PLACE OF DEATH
County Gentry
Township Bogle
City (No. St. Ward)
Registration District No. 311
Primary Registration District No. 3430
File No.
Registered No.

2. FULL NAME Effie Abarr
(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)
Female	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife of Milage L Abarr Sr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7-1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	55	9	00	

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) near Albany
(STATE OR COUNTRY) Gentry County MO

PARENTS
10. NAME OF FATHER John Green
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Sarah Jane Glendening
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Gentry County MO

14. INFORMANT Milage L Abarr Sr
(Address) Albany MO

15. FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930 to Jan 6, 1930
that I last saw her alive on Jan 4, 1930 and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82a
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

744

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. Watten M. D.
10, 1930 (Address) Albany 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 New Friendship
DATE OF BURIAL Jan 9 1930
20. UNDERTAKER T R Shockley
ADDRESS Albany Mo.

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 Gentry Registration District No. 311 File No.
Township Bogle Primary Registration District No. 3430 Registered No.
City (No. St. Ward)

2. FULL NAME Effie Abaw

(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.

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 laymen can understand it. Exact statement of OCCUPATION is very important.

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

WRITE PLAINLY, IN UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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. Jan 6 1930 C. N. Williamson
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1930

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