

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

Do not use this space.

1755

1. PLACE OF DEATH

County Laurel Registration District No. 471
 Township Pence Primary Registration District No. 6284
 City Pence City, Mo. (No. 1) St. 1 Ward 1

2. FULL NAME

Bella Major
 (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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 6 6

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Home 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) Ills.

10. NAME OF FATHER James Kirkpatrick

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

12. MAIDEN NAME OF MOTHER Alice King

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

14. INFORMANT Dona Seibert
 (Address) Joplin Mo.

15. FILED 1/17 19 30 H Ross Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1930 to Jan. 16 1930 and that I last saw her alive on Jan. 16 1930 and that death occurred, on the date stated above, at 5:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Hypertension
93E

(duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 93E

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? Int DATE OF _____

WAS THERE AN AUTOPSY? Int

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) [Signature] M. D.

, 19 (Address) [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 City Cemetery DATE OF BURIAL Jan 18 1930

20. UNDERTAKER John Fossell Jr ADDRESS Pence City 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.

FEB 19 1930

